Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

December 24, 2008

Michael Marshall
Secretary of Senate
State Capitol
LOCAL

Mark Brandsgard
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Marshall and Mr. Brandsgard:

Enclosed please find copies of reports to the General Assembly relative to the Medical Assistance Quality Improvement Council.

These reports were prepared pursuant to directive contained in HF 2539.

Legislative members have not been appointed to this council to date, but Medicaid is actively involved in quality improvement efforts and has activities underway in several areas. The following are Medicaid programs and initiatives:

- The federal Centers for Medicare and Medicaid Services (CMS) recently completed a comprehensive assessment of Iowa Medicaid & SCHIP Quality Improvement Activities – The accomplishments state that Iowa Medicaid efforts are consistent with the Value Driven Health Care Initiative. The quality improvement assessment provides a framework to capture at a high level the improvement activities in support of the Medicaid & SCHIP programs. The CMS final report is available and will be included in the final report.
- The Iowa Medicaid Enterprise (IME) designed and implemented the Medicaid Value Management (MVM) Initiative – MVM is a comprehensive approach to improve the quality and value of services provided to Iowa Medicaid members. Our goal is to maximize the value of the program to Medicaid members within the fiscal limitations of the state and federal budget. Utilizing nationally recognized benchmarks and data on utilization of services we identify gaps in care and evaluate current Medicaid services to members. Results of the claims review data form the basis of recommendations for improving the quality of health care, identifying opportunites for cost containment and addressing gaps in care. The state fiscal year 2008 MVM report will be included in the final report.
- IME Care Management Programs – Iowa Medicaid has four disease/care management programs that integrate condition care management (asthma, diabetes and congestive heart failure) and complex care management into a proactive approach to health care delivery. The programs address the medical needs of Medicaid members with chronic diseases. The programs take a holistic approach by conducting depression screenings, introducing self-management skills and coordinating accessing to high quality health care. Care management programs direct interventions that ensure right care at the right time while encouraging Medicaid members to assume responsibility for their health. The evaluation report for the congestive heart failure care management program will be included in the final report.

- The IME uses "HEDIS" Measures and CAHPS – Iowa Medicaid measurement information is collected and published by U of I Public Policy Center annually. The results are evaluated and utilized in quality improvement initiatives. HEDIS measures are used to compare the performance of the Medicaid program to that of other state Medicaid and the commercial plans. HEDIS data provide benchmarks on which to evaluate Iowa Medicaid performance. The SFY 2008 report will be included in the final report.
- Iowa Medicaid Electronic Records System (IMERS) – The IME designed and implemented a web-based electronic tool that enables providers to review services and medications of their Medicaid members to improve the quality of care by decreasing drug interactions and duplication of services. Medicaid is exploring how other state agencies may use this tool to perform their services (LTC, WIC, Foster Care).
- Waiver Quality Management Plans – The Iowa Home and Community Based Service waiver program has developed a comprehensive Quality Management plan designed to meet the CMS Quality Framework guidelines for the Medicaid waiver programs. The Quality Framework establishes a common frame of reference for states to use to address quality issues and to focus attention on desired participant outcomes and program design. The HCBS Quality Management plan identifies and monitors performance measures in seven focus areas identified in the Quality Framework. The plan will be included in the final report.

Sincerely,

Jennifer Vermeer
Medicaid Director

Attachments
1. CMS Review of IME Quality Programs
2. Medicaid Value Management Report
3. Report on IME Congestive Heart Failure Program
4. Outcomes Report on Medicaid Managed Care (using HEDIS and CAHPS)
5. Waiver Quality Plan

cc: Governor Culver
Legislative Service Agency
Kris Bell, Senate Majority Caucus
Peter Matthes, Senate Minority Caucus
Zeke Furlong, House Majority Caucus
Brad Trow, House Minority Caucus

Assessment of Medicaid and SCHIP Quality Improvement Activities for the State of Iowa September 2008

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

September 18, 2008

Eugene Gessow, Medicaid Director
Division of Medical Services
Department of Human Services
100 Army Post Road
Des Moines, Iowa 50315

Dear Mr. Gessow:

We are pleased to share with you this packet of information intended to support quality improvement efforts in your State Medicaid program.

Background

CMS has established the Medicaid Quality Improvement Program (MQIP) which serves to fulfill the objectives of the Medicaid Quality goal established through the Federal Government Performance and Results Act (GPRA). One of the objectives of the goal calls for the Centers for Medicare & Medicaid Services (CMS) to work in partnership with State Medicaid Directors to develop a National Medicaid Quality Framework that will articulate broad principles and a common vision of quality for the program. The other objective of the GPRA goal seeks to enhance the ability of States to assess improvements in access and quality of health care under their Medicaid programs. Both objectives were discussed in a letter sent to all State Medicaid Directors on April 25, 2007 (http://www.cms.hhs.gov/SMDL/SMD/list.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&intNumPerPage=10).

Focusing on the latter of these two objectives, this packet presents an array of information about access and quality of care in your Medicaid and State Children's Health Insurance Program (SCHIP) program. We have compiled information on many of Iowa's activities across settings and delivery systems in an effort to provide a comprehensive assessment of activities, which in their totality, work to achieve the quality improvement goals of your State. We are providing this information to you to establish a baseline that can help you assess the current state of access and quality in your program, identify opportunities for improvement, and provide a basis for future collaborative efforts. In conducting this analysis, you may wish to supplement the contents of this Report with information available from your own internal sources, as well as information disseminated by external organizations, such as the Commonwealth Fund report, U.S. Variations in Child Health System Performance: A State Scorecard,

http://www.commonwealthfund.org/usr_doc/site_docs/slideshows/ChildScorecard/ChildScorecard.html.

Some of your State's efforts referenced in this packet also advance the four cornerstones of the Department of Health and Human Services' Value Driven Health Care initiative:

- Interoperable Health Information Technology (HIT)
- Transparency of Quality Information (measuring and publishing quality information)
- Transparency of Price Information (measuring and publishing price information)
- Incentives for High-Value Care (creating positive incentives for high quality health care purchasers)

Activities undertaken in support of these cornerstones help achieve multiple goals:

- Improve health outcomes through the exchange of clinical data among payers and providers,
- Reduce costs through increased administrative efficiencies,
- Enhance the ability of consumers to make informed health care decisions,
- Help providers and plans identify opportunities for quality improvement,
- Encourage providers to deliver high value care and consumers to adopt healthy behaviors,
- Support research into the effectiveness of alternative clinical approaches, and
- Reduce national health care expenditures.

Secretary Leavitt has asked governors, county executives and mayors to support the four cornerstones of value-driven health care and to encourage the health insurance plans, third party administrators, providers, and others with which they contract to take consistent actions to achieve these goals. The VDHC website (www.hhs.gov/transparency/government/index.html) indicates that four Iowa cities (Ames, Burlington, Cedar Rapids, and Des Moines) have endorsed the principles of this initiative. For practical steps that your State can take to further advance these goals, we suggest that you refer to "Value-Driven Health Care: A Guide for State Medicaid Agencies, Version 1.0-May 2007" (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_%20and_Protocols.asp#TopOfPage).

Components of Packet and Summary

This packet consists of the following components:

- Tab A - Quality Summary:
  Performance measures, other data, and descriptions of current State initiatives that provides a snapshot of quality in your Medicaid program.
- Tab B - Data Reflective of Iowa's Broad Quality Efforts:
  2007 State Snapshot for Iowa developed by the Agency for Healthcare Research and Quality

- Tab C – Data Reflective of Iowa's Quality Efforts Related to Children's Health
  - CMS Analyses and Initiatives:
    - CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program
    - CMS Analysis of Immunization Status of Iowa's Medicaid Children ages 19 – 35 months
    - CMS Childhood Obesity Initiatives and link to Childhood Obesity Report Card for Iowa by the Childhood Obesity Action Network of the National Initiative for Children's Healthcare Quality (NICHQ).
  - Analyses and Initiatives Developed by Other Organizations:
    - Snapshot of Child Health Needs and System Performance: Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (June 15, 2006)
    - Commonwealth Fund: 2008 State Scorecard on Child Health System Performance
    - Maternal and Child Health Bureau – Iowa's State Priority Needs
    - Title V Maternal and Child Health Block Grant Performance Measures – Iowa
- Tab D - CMS Comments on the Iowa's 2007 Quality Strategy for Managed Care
- Tab E - Comments on Iowa's 2006-7 External Quality Review Annual Technical Report;
- Tab F - Medicaid Information Technology Architecture (MITA): An Opportunity to Improve Medicaid Quality
- Tab G - Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations – Iowa
- Tab H - CMS Regional Office Reviews of Iowa Home and Community Based Services Waiver Programs
- Tab I - Data from CMS Hospital Compare and Nursing Home Compare Databases
- Tab J - 2007 State Children's Health Insurance Program (SCHIP) Data: Iowa

Summary of Findings from Review of Information

The CMS Medicaid and SCHIP Quality Strategy published in 2005 and revised in 2006 (see Appendix D of Tab D) was used as the primary assessment framework to analyze the State's progress in moving towards the Strategy pillars listed below. Additionally, considerable attention was given to the State's EPSDT screening rates and regulatory activity related to State Quality Strategies and External Quality Reviews for managed care delivery systems. In this regard the overall assessment was primarily based on the State's use of:

- Evidenced Based Guidelines and Performance Measures to improve the quality of care delivered to beneficiaries;

- Health Information Technology to support quality and efficiency;
- Value-Base Purchasing strategies to align payment and quality;
- Activities designed to reduce health care disparities;
- Partnerships and collaborations to promote care coordination and leverage resources;
- Information Dissemination/Transparency (e.g. public reporting);
- The State Quality Strategy, External Quality Review (EQR) activities, and HCBS Quality Management Plans to achieve stated goals; and
- EPSDT services as reflected in the State reported CMS-416.

Collectively, these efforts, as well as many others referenced throughout the document, should enhance the State's ability to provide safe, effective, person-centered, timely, efficient and equitable care.

Selected Accomplishments

Iowa is actively involved in quality improvement efforts and has activities underway in many of the above referenced assessment areas. The State covers telemedicine services and exchanges information with registries for immunizations and several chronic conditions. We note that the State uses nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS©) performance measures and measures similar to HEDIS to track 14 of the 39 performance measures captured in Section IV of the attached *Quality Summary*. Iowa also uses a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument to assess member satisfaction, access and utilization of services.

The State publishes nursing facility accountability measures, as well as HEDIS measures for the Iowa Plan section 1915(b) mental health/substance abuse carve out., on its website. The Iowa Department of Public Health also publishes EPSDT participation, dental, and blood lead screening rates by county to enable providers and planners to compare local performance to statewide rates.

Incentive payment systems have been implemented for hospitals, managed care plans, and nursing facilities. Evidence based guidelines are utilized in disease management and case management efforts and in support of high-quality long term care services. Iowa's Primary Care Case Management program and 2008 legislation support the establishment of medical homes for beneficiaries. Medicaid has developed a Congestive Health Failure monitoring program using telemedicine technology. We also note that the State reports that it was an early adopter of Medicaid Information Technology Architecture principles and has completed the self assessment requested by CMS. Iowa has received a multiple CMS grants and has been an early adopter of several home and community based services initiatives.

Iowa ranks sixth best in the percent of overweight or obese children in the State. The State has received an Agency for Healthcare Research and Quality rating of "strong", compared to other States, based on a summary of over 100 measures in the National

Healthcare Quality Report (NHQR). Iowa's overall 2006 immunization rate of 78.9 percent exceeds the national average of 77.5 percent.

The Iowa Quality Strategy is a thoughtful and well-drafted document. The physical and behavioral health components of Iowa's Quality Strategy adequately meet all regulatory requirements for State quality strategies

Several of the State's more innovative quality efforts have been recognized by CMS and national organizations. The CMS Home and Community Based Services (HCBS) promising practices website profiles the Certified Nursing Assistants Recruitment and Retention Project, an effort to address turnover among support staff in Iowa nursing homes that may be adapted to HCBS services. Iowa is one of several States that has implemented a Cash and Counseling project to provide Medicaid-eligible frail elderly persons and disabled individuals of all ages with an annual budget that participants may use to pay for the combination of goods and services that best meets their personal care needs.

Iowa reported data for all four core measures on the 2007 SCHIP annual report. The rate for well child visits in the first 15 months increased by 8.5 percentage points between 2006 and 2007. The percent of children in each age group measured who used appropriate asthma medications rose consistently and considerably over the three-year period, 2005-2007.

Recommendations for Continuous Improvement

Iowa may wish to consider expanding the number of performance measures indicated in Section IV of the Quality Summary (Tab A) for which the State collects data. For example, reporting on infection rates is a key indicator used in identifying Never Events. Reporting on neonatal care, prenatal care, and obesity can facilitate necessary interventions to assure optimal infant and child health. Your State's Early and Periodic Screening Diagnoses and Treatment (EPSDT) participation rate declined 3 percentage points from 71 percent in fiscal year (FY) 2006 to 68 percent for FY 2007. We urge Iowa to continue its efforts to reach the national participation goal of 80 percent. We also encourage Iowa to enhance its efforts to improve its EPSDT dental service and blood lead screening rates, which are 43 percent and 9 percent, respectively. While the State ranks among the top States in the percent of overweight and obese children overall, its rates for children with low family incomes and on public insurance are about average. We encourage Iowa to explore new strategies for addressing this health problem among Medicaid-eligible children.

The most recent External Quality Review Annual Technical Report for Iowa that CMS has received is for the years 2006-7. We look forward to seeing future reports that show enhanced documentation and data analysis associated with Performance Improvement Plans, as well as initiation of improvement strategies based on the results of performance measurement.

With regard to Iowa's 2007 Quality Strategy, we recommend that the State integrate the two Quality Strategies for physical and behavioral health into a single document that incorporates quantified, measurable performance targets. CMS would also appreciate more information from Iowa in the Quality Strategy on its participation in pay for performance, health information technology, Never Events, and other value-based purchasing initiatives.

We note that, while various organizations have recognized practices undertaken by the State to advance quality, Iowa has not submitted profiles of any such efforts for posting on the Medicaid/SCHIP Promising Practices website hosted by CMS (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage). We encourage you to review the process for nominating a practice (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNomination%20Process.asp#TopOfPage) and to submit your nominations so that beneficiaries in other States can benefit from the progress that is being made through your efforts.

We encourage Iowa to continue to incorporate HIT-related goals and refer to national standards in its Quality Strategy and next ATR. We have included a concept paper on quality and CMS's Medicaid Information Technology Architecture (MITA) initiative and would appreciate your feedback on the State's intentions to adopt MITA principles in its Medicaid information systems. We would also like to learn more about current efforts to address health care disparities in the State, as this continues to be a priority area.

Given that the Iowa Department of Human Services administers both the Medicaid and SCHIP programs, we offer several recommendations to improve the completeness of the data reported via the SCHIP Annual Report Template System (SARTS) and to clarify the data submitted on the 2007 report. We encourage the State to examine the reasons for the decline in the number of 4- and 5-year olds who received well child visits between 2005 and 2007 and for the low percentages of 6-year olds receiving well child visits in each of these years. We would appreciate the State's efforts to provide the percent of children in the first 15 months who receive specific numbers of visits. We will be glad to provide technical assistance to enhance the State's reporting of each of these measures.

We have included more specific comments related to the above summary in attachment A of this letter. Detailed information regarding each item can be found in the subsequent attachments.

Requested Follow-up Actions

Please provide written acknowledgement of receipt of this information as well as any necessary corrections and additions to the information to ensure accuracy. We would like to particularly call your attention to the *Quality Summary* that can be found in Tab A as that portion of this assessment will eventually be available for public review.

We would also like to request feedback indicating how the Iowa Medicaid and SCHIP programs intend to use the information presented in this packet as well as other sources of information to improve access and quality to Medicaid services. We would appreciate receiving your feedback by November 7, 2008 as this will help as we further develop the State Quality Assessment Process for other States. Your feedback should be sent to the attention of James Scott, Associate Regional Administrator for Medicaid and Children's Health Operations in the CMS Kansas City Regional Office, at James.Scott1@cms.hhs.gov.

Additionally we are interested in learning the extent to which Iowa has found this information to be useful, and what other information CMS could supply or help the State develop to support its Medicaid quality improvement efforts.

We appreciate your commitment to improving quality for the children, families, aged, blind and disabled beneficiaries covered through your Medicaid and SCHIP programs and look forward to working with you in these efforts. Please feel free to contact me or any member of my staff to discuss this information in more detail. I can be reached at 410-786-0505 or john.young@cms.hhs.gov.

Sincerely,

John M. Young
Acting Director, Division of Quality, Evaluation, and Health Outcomes

Executive Summary:
Information to Support the Assessment of Quality Improvement
by the State of Iowa's Medicaid Program

Following is a summary analysis of the key documents included in this packet:

- Quality Summary (Tab A) – The *Quality Summary* is designed to serve as a quick reference of quality improvement activities in the State of Iowa. We ask that you carefully review this document as this information in the *Quality Summary* will eventually be made public.

    - In Section II, Iowa reports activity in all four principal areas of Value Driven Health Care: Interoperable Health Information Technology, Measurement and Publication of Quality Information (Quality Standards), Measurement and Publication of Price Information (Price Standards), and Promoting Quality and Efficiency of Care (Incentives/Pay for Performance).

    - In Section III, Iowa indicates that it promotes quality in all six areas identified in the CMS Medicaid/SCHIP Quality Strategy: Evidence Based Guidelines/Performance Measures, Value-Based Purchasing/P4P, Health Information Technology, Racial/Ethnic Disparities Projects, Medical Home Models, and Partnerships/Collaboration. The State is engaged in various local and Federal collaborative efforts to advance health information technology and child health.

    - The State collects and reports 14 of the 39 nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS©) performance measures and measures similar to HEDIS identified in Section IV.

    - Some of the State's more innovative quality efforts have been recognized by CMS and national organizations. The CMS Home and Community Based Services (HCBS) promising practices website profiles the Certified Nursing Assistants Recruitment and Retention Project, and the Agency for Healthcare Research and Quality profiles Iowa's Cash and Counseling project. The State has also identified several other noteworthy initiatives.

- Data Reflective of Iowa's Broad Quality Efforts (Tab B) –

    - Agency for Healthcare Research and Quality 2007 State Snapshot – Iowa: This AHRQ analysis indicates that your State has a strong overall rating in comparison to other States on a series of quality measures. It highlights measures in which Iowa performed best in comparison to other States and identifies other measures that provide opportunities for improvement.

- Information Reflective of Iowa's Quality Efforts Related to Children's Health (Tab C) –

    - CMS Analyses and Initiatives:

        - CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program: Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program: The State's form CMS-416, the EPSDT annual reporting form, indicates that for FY 2007 Iowa's participation ratio was 68 percent, its dental services rate was 43 percent, and its lead screening rate was 9 percent.

        - CMS Analysis of Immunization Status of Iowa Medicaid Children ages 19 – 35 months: Iowa's overall rate for 2006 is 78.9 percent, compared to a national average of 77.5%. The number of Medicaid children was not specifically measured, but the number of children in the Vaccines for Children Program (VFC) in Iowa with full immunizations was 77.0 percent, compared to a national VFC coverage rate of 79.8%. The majority of VFC participants are Medicaid children, and VFC is the primary source of Medicaid immunizations.

        - CMS Childhood Obesity Initiatives: The State ranks sixth best among all States in percentage of children ages 10-17 who are considered overweight or obese according to Body Mass Index-for-age standards. The State's overall prevalence of childhood obesity is about five percentage points lower than the national average. The percentage of overweight or obese children is comparable to national averages for children in low-income families and those covered by public insurance.

    - Analyses and Initiatives Developed by Other Organizations:

        - Snapshot of Child Health Needs and System Performance: Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (June 15, 2006): This resource indicates Iowa's performance on various indicators in the domains of Health Needs and Health Outcomes and in Performance and Improvement Opportunities in comparison to its region and the nation.

        - Maternal and Child Health Bureau – Iowa State Priority Needs: Through a Statewide maternal and child health needs assessment

required by Title V legislation, the State of Iowa has established 10 priority needs. Priority needs of particular relevance to the Medicaid-eligible children relate to the provision of developmental evaluations, access to pediatric specialty care, quality of primary care, access to oral health care, reduction of infant mortality, and access to necessary mental health services for pregnant and parenting women. We would appreciate information concerning the State's participation in activities to address these priorities with regard to Medicaid populations.

- Title V Maternal and Child Health Block Grant Performance Measures – Iowa: The State reports on six performance measures that represent selected indicators of statewide quality, as required by the Title V Maternal and Child Health Block Grant program. Those of particular relevance to the Medicaid-eligible children generally correspond to the priority needs discussed above.

- CMS Comments on the Iowa 2007 Quality Strategy (Tab D):

  - The Iowa Quality Strategy is a thoughtful and well-drafted document. The physical and behavioral health components of Iowa's Quality Strategy adequately meet all regulatory requirements for State quality strategies.

  - CMS recommends that the State integrate the two Quality Strategies for physical and behavioral health into a single document that incorporates quantified, measurable performance targets.

  - CMS would also appreciate more information from Iowa in the Quality Strategy on its participation in pay for performance, health information technology, and other value-based purchasing initiatives.

- Iowa External Quality Review Organization (EQRO) 2006-7 Annual Technical Report (ATR) (Tab E):

  - CMS views the External Quality Review process as a mechanism that can be more effectively used to help the State reach its quality goals as stated in the State Quality Strategy. We continue to explore best practices in how to use the process more effectively and would appreciate your feedback in this area.

  - CMS encourages the State to submit a single EQRO report that provides summary and comparative information for all participating MCOs and PIHPs in the future.

- Medicaid Information Technology Architecture (MITA): An Opportunity to Improve Medicaid Quality Medicaid Information Technology Architecture

(MITA): An Opportunity to Improve Medicaid Quality (Tab F) – This paper is intended to provide an overview of MITA and Quality for MMIS and Quality professionals.

- The Medicaid Information Technology Architecture (MITA) framework seeks to move the MMIS toward a greater focus on the beneficiary, integration of clinical and administrative data, support of program analysis and decision making, and an enhanced capacity for Medicaid to communicate with other programs and payers.

- The MITA initiative can support quality improvement by providing a more comprehensive base of information on individual beneficiaries and real-time data on changes in the delivery of services in real time.

- A July 2007 report issued by the DHHS Office of Inspector General cited numerous examples of State Medicaid HIT and HIE initiatives intended to serve these aims.

- CMS intends to take a series of concrete actions to explore opportunities for using MITA principles to advance quality goals for Medicaid beneficiaries

- Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations – Iowa (Tab G):

  - CMS-Posted Promising Practices:

    - Iowa has no promising practices on the CMS Medicaid/SCHIP Quality Website.CMS encourages Iowa to submit descriptions of any innovative initiatives undertaken through your Medicaid managed care plans that advance quality for Medicaid beneficiaries or SCHIP enrollees using the guidelines and format found on the CMS Medicaid/SCHIP Quality website (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNominationProcess.asp#TopOfPage). See examples of promising practices for other States already posted to this site (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage).

    - The Home and Community Based Services promising practices website (http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp#TopOfPage) profiles the State's Certified Nursing Assistant (CNA) Recruitment and Retention Project, which seeks to address the need for direct support professionals in both institutional and community settings.

- CMS-Posted Promising Practices: National organizations have recognized Iowa's quality-related efforts as well: AHRQ's Health Care Innovations Exchange website (http://www.innovations.ahrq.gov/content.aspx?id=1800) profiles Iowa's Cash and Counseling project, which provides frail elderly and disabled individuals of all ages with Medicaid coverage with an annual budget, which the participant uses to pay for the combination of goods and services that best meets their personal care needs.

- CMS Regional Office (RO) Reviews of Iowa Home and Community Based Services (HCBS) Waiver Programs (Tab H) – Summaries of RO reviews of the five following HCBS waiver programs are furnished:
  - Elderly
  - Physically Disabled
  - Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

- Data from CMS Hospital Compare and Nursing Home Compare Databases (Tab J) - We have included national averages and averages for Iowa hospitals from the CMS Hospital Compare website (http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home) for 24 measures in four areas (i.e., Myocardial Infarction, Health Failure, Pneumonia, Surgery). Also included are national averages and averages for Iowa nursing homes from the CMS Nursing Home Compare website (http://www.medicare.gov/NHCompare/Home.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True) for 19 measures. These measures reflect the quality of care received by Medicaid and beneficiaries and SCHIP enrollees as a part of the overall population.

  We encourage you to review these data and the facility-specific rates on the CMS websites. Iowa can obtain information about Medicaid hospitalizations using HCUPNet (www.hcupnet.ahrq.gov). By providing information on hospital discharges (e.g. length of stay, charges) for a variety of diagnoses and procedures, HCUPNet would enable the State to compare Medicaid versus other payers.

- 2007 State Children's Health Insurance Program (SCHIP) Data: Iowa (Tab J) – CMS requires State SCHIP programs to report annually on four core child health performance measures:

  - Well Child Visits in the First 15 Months of Life
  - Well Child Visits in the Third, Fourth, and Sixth Years of Life
  - Use of Appropriate Medications for Children with Asthma
  - Children's Access to Primary Care Practitioners

- Iowa reported data for all four core measures on the 2007 SCHIP annual report. The rate for well child visits in the first 15 months increased by 8.5 percentage points between 2006 and 2007. The percent of children in each age group measured who used appropriate asthma medications rose consistently and considerably over the three-year period, 2005-2007.

- The number of 4- and 5-year olds who received well child visits declined between 2005 and 2007. Relatively low percentages of six-year olds received well child visits in each of these years. The State indicated the percent of children in the first 15 months who received any well child visits but not the number who received a specific numbers of visits (i.e., 0, 1, 2, 3, 4, 5, 6).

Tab A

Quality Summary

Quality Summary for the State of Iowa

I. State Contact Information:

Name/Title:	Jennifer Vermeer, Assistant Medicaid Director
Organization:	Iowa Medicaid Enterprise
Street Address:	100 Army Post Road
City/State/Zip Code:	Des Moines, IA 50315
Telephone:	515-725-1144
Email Address:	Jvermee@dhs.state.ia.us

II. Value Driven Health Care:

1.**Interoperable Health Information Technology (*HIT Standards*)**

☒ Yes ☐ No (*if yes, see checked box below*)

☒ Adoption of Medicaid Information Technology Architecture (MITA) Early adopter – self assessment completed	☒ Remote Monitoring/Telemedicine Underlying service payable – not transmission/hardware Used considerably for mental health delivery Remote evaluations for enclosed bed therapy - nighttime video evaluated remotely to determine tolerance by the patient for an enclosed bed used to promote safety.
☐ Electronic Medical Record (EMR)	☒ Electronic Health Record (EHR) The Iowa Medicaid Electronic Records System (IMERS) is a web-based tool that organizes and displays information from the State's claims data warehouse for the provider in an EHR format to support patient care.
☒ Patient/Disease Registries Used by the State's medical reviewer contractor to support diagnosis-based medical/disease/care management for: Diabetes Congestive Heart Failure Asthma Individuals with multiple, complex care needs	☒ Information Exchange/Collaboration Immunization Registry with Iowa Department of Public Health (IDPH)

2. **Measure and Publish Quality Information (*Quality Standards*)**

☒ Yes ☐ No

How/where are these measures published? On State website?

The State publishes:

(1) HEDIS measures published at http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html

(2) Iowa Plan 1915(b) mental health/substance abuse program performance measures published at http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html

(3) Nursing facility accountability measures published – You can find the last posted Acct Measures at: http://www.ime.state.ia.us/Providers/Forms/NursingFacilityRates.html

3. **Measure and Publish Price Information (*Price Standards*)**

☒ Yes ☐ No

All fee schedules are published on http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

4. **Promote Quality and Efficiency of Care (*Incentives/Pay for Performance*)**

☐ Hospital ☐ Physician ☐ Home Health ☒ MCO ☒ Other **Nursing Facility**

(1) **Iowa Plan (Incentives)** – Additional payments for benchmark practices. Under the Iowa Plan (managed behavioral health contract) funds are set aside for community reinvestment programs. Community reinvestment is a specified portion of the monthly capitation payment that is intended to pay for innovative practices that become required services and self-supporting. The program contains extra payments by the Iowa Plan for benchmark practices. These can include paying providers contracted with the Iowa Plan for achieving specific goals relative to the project that impact the quality of care provided.
(2) **Iowa Plan (Incentives)** - In addition, the Iowa Department of Human Services holds the contract with the current Iowa Plan contractor and has agreed to make incentive payments to the contractor for the achievement of specific performance measures. These measures are developed by the Clinical Advisory Committee and sent to the Iowa Plan Advisory Committee, consisting of consumers, advocates, providers and others. The Iowa Plan Advisory Committee makes a recommendation to DHS as to whether or not to accept, amend or drop any specific measures.
(3) **Nursing facility accountability measures (P4P)** - State legislation required Iowa Medicaid to initiate a system to measure a variety of elements to determine a NF capacity to provide quality of life and appropriate access to medical assistance program beneficiaries in a cost-effective manner. To do so, Iowa Medicaid was to implement a process to collect data for measurements and develop procedures to increase NF payments based on achievement of multiple favorable outcomes. Iowa's NF Accountability Measures were developed to be objective and measurable NF characteristics that indicated either quality care, efficiency, or commitment to care for special resident populations. The Accountability Measure is calculated by facility (if the criteria are met) and then is an add on to their rate.
(4) **Hospital participation in Diagnosis Related Groups (DRG)/Ambulatory Patient Groups (APG) (General promotion of efficiency of care)** – Iowa has adopted hospital reimbursement methodologies that are dependent upon the specific condition of the individual. DRGs were developed by Medicare to promote efficiency of care.

III. CMS Medicaid / CHIP Quality Strategy Pillars

☒ Evidenced Based Guidelines/ Performance Measures (See Section IV) HEDIS Measures AHRQ Learning Project to encourage information	☒ Value-Based Purchasing/P4P – (See Section II – Incentives) Refer to #4 – Section II **See comment in Section II,**	☒ Health Information Technology (See Section II) Medicaid has joined other payers and providers on an Information Technology Commission established by State legislation IMERS electronic health record (Section II)

sharing among States regarding strategies for developing and implementing disease management programs Used for prior authorization, disease management, utilization management, and case management programs Quality Assurance programs for Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded	**subsection 4.**	
☒ Racial/Ethnic Disparities Projects Community Reinvestment project for Urban Dreams funded as a pilot project under Iowa Plan section 1915(b) program	☒ Medical Home Models Primary Care Case Management program 2008 Legislation for establishment of medical home Care Management program Disease Management program Iowa safety net provider collaboration Health Care Reform bill (2008) – House File 2539 contains a number of measures designed to advance coverage of the uninsured and improve the health care system in Iowa.	☒ Partnerships/Collaborations The State has joined Des Moines University in a partnership to monitor Congestive Heart Failure patients via telephone. Started as a grant program. Now Medicaid-funded. Medicaid has a partnership with the Department of Public Health on a number of initiatives included the states smoking cessation programs, EPSDT services, and dental access issues. Medicaid collaborates with the University of Iowa in developing HEDIS data to monitor and report on EPSDT participation. The State was one of five States selected to participate in the ABCD II Consortium, which began its work in early 2004. With funding from the Commonwealth Fund, the National Academy for State Health Policy administers the ABCD II initiative, a three-year project designed to build state capacity to deliver care that supports children's healthy mental development. Iowa Medicaid works with the University of Iowa on this initiative. Medicaid works with various partners on the Medical Assistance Advisory Committee in reviewing program performance.

	One of these measures is implementation of a medical home model. There is a workgroup that has been appointed to design the program. Medicaid and SCHIP will be the first phase of implementation, per the legislation.	Medicaid works with private clinicians on the Clinical Advisory Committee to review utilization of acute care, prior authorization, and utilization trends. Medicaid convenes a Pharmaceutical and Therapeutic Committee to make recommendations on the Preferred Drug List and a Drug Utilization Review Committee to make recommendations on clinical prior authorization requirements. Both groups consist of community physicians and pharmacists. Medicaid works with the State Department of Inspections and Appeals on fraud and abuse investigation and survey and certification.

Comments:

IV. Performance Measures: ☒HEDIS ☒HEDIS-Like ☐Hospital Quality Alliance (HQA) ☒Other (See comments)

☒ Access	☒ Dental	☐ Hypertension	☐ Obesity
☐ Acute Myocardial Infarction (AMI)	☒ Depression	☐ Intensive Care Unit (ICU) Care	☐ Patient Safety
☐ Ambulatory	☒ Diabetes	☐ Infection	☒ Pediatric
☒ Asthma	☐ Efficiency	☐ Health Literacy	☐ Pediatric Intensive Care Unit (PICU) Care
☐ Bone Conditions	☐ Emergency Department	☐ Liver Disease	☐ Pneumonia Care
☒ Cancer Screenings	☐ End Stage Renal Disease (ESRD)	☒Medication	☐ Prenatal Care
☒ Care Coordination	☒ Heart Failure	☒ Mental Health	☒ Prevention
☒ Children with Special Health Care Needs (CSHCN)	☐ Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)	☐ Neonatal Care	☐ Respiratory
☐ Coronary Artery Disease (CAD)	☐ Home Health	☐Nursing Home	☐ Vision
☐ Sickle Cell Anemia	☐ Surgical Infection Prevention (SIP)	☒ Thyroid Disease	☐ Other

Comments:
(1) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for member satisfaction, access and utilization of services.
(2) Measurement information collected and published by University of Iowa Public Policy Center.

V. Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)

☒ Participation Rate:	☒ Dental Service Rate:	☒ Lead Screen Rate:

Comments:
Iowa's EPSDT annual reporting form (CMS-416) for fiscal year 2007 indicates the following:

Participation Goal: The State of Iowa's FY 2007 participation ratio is 68%, a decrease of 3% from FY 2006. The national participation goal continues to be 80%.

Dental Services: For FY 2007, the data shows that the State provided some dental service to approximately 43% of eligible EPSDT individuals, an increase of 1% from FY 2006.

Lead Screening: For FY 2007, the data shows the State has provided a lead screening test to just 9% of the eligible EPSDT population under the age of 6 who should have had a screening blood lead test. This is a decrease of 2% from FY 2006. Blood lead screening continues to be a requirement under the federal Medicaid program for all children ages 1 and 2 as well as a blood test for any child under the age of 6 for whom no record of a test is available.

The IDPH publishes the above rates by county so that providers and planners can get a picture of the rates locally in addition to the statewide rates.

The State has set performance measures in the current year's IDPH contract for dental rates.

VI. Recognition of Promising / Innovative Practices

☒ Recognition by CMS	☒ Recognition by Other Health-Related Organization

Comments:

- **The Certified Nursing Assistants Recruitment and Retention Project**: This Project is profiled on the CMS Home and Community Based Services (HCBS) promising practices website.
- **Iowa Plan:** Iowa has received requests for information regarding the Iowa Plan, contract and performance measures.
- **Lock-In Program:** CMS, during the MIG visit recognized Iowa Medicaid's Lock-in program for making four provider types eligible for Lock-in status (including hospital and specialty physicians).
- **Nursing home accountability measures:** Iowa's NF Accountability Measure program has been recognized by other states and provider associations as the first in the nation and model program that focuses increased nursing facility payments based on provider performance.
- **Habilitation:** Iowa was the first state in the nation to implement a 1915i HCBS State Plan, which is a new option available under the Deficit Reduction Act to provide Home and Community Based Services under the State Plan
- **Care Management Coordination:** AHRQ Care Management Learning Network and the Medicaid Medical Director's Association have both recognized Iowa Medicaid's integration of behavioral and physical medicine through the completion of depression screening and its impact on chronic care.

- **Consumer Choices Option under HCBS waivers:** This self-direction option was initially awarded a Robert Woods Johnson Real Choices grant to add the service to six of Iowa's HCBS waivers. This option allows Medicaid members to have control over a targeted amount of HCBS funding to develop an individual budget. The individual budget plan allows the member to hire employees and/or purchase other goods and services. The project is profiled on AHRQ's Health Care Innovations website.
- **Money Follows the Person grant:** Iowa received a five-year grant from the Centers for Medicare and Medicaid Services (CMS) to provide opportunities for 528 people to move out of Iowa's ICF/MR facilities to independent settings of their choice. Grant funds provide the transition services and extra supports needed for the first year after they transition into the community.
- **Medicaid Infrastructure Grant:** The purpose Iowa's grant program people with disabilities and advocates working together with state government to enhance opportunities for Iowans with disabilities to work and live in the community of their choice.

VII. State Quality Strategy

☒ Document Title: Quality Assessment and Improvement Strategy	☐ Date of Last Quality Strategy: 2007
Comments:	

VIII. External Quality Review

☒ EQRO: Iowa Foundation for Medical Care	☐ Date of Last EQRO Report: 2006-2007
Comments:	

IX. Other Quality Initiatives

☒ Childhood Health Initiatives	☒ Other Quality-Related Studies

Comments:
(1) SCHIP focused study on health status improvement. The Health Assessment Survey project under which the State works with researchers and the SCHIP Clinical Advisory Committee to develop survey instruments that are used to evaluate the effect of the SCHIP participating health and dental plans on access to care, health status and family environment of enrolled children is used. Parents respond to a survey given at the time the child joins the SCHIP program (the baseline survey). These responses are compared with their responses to a survey given after their child had been enrolled for about a year (the

follow-up survey) to determine if there are differences in the perceived ability to receive health services or their child's health status.

(2) Coordination with immunization registry.

(3) The State is working to educate physicians and other primary care providers on the need for developmental surveillance and standardized screening according to the American Academy of Pediatrics guidelines.

(4) Title V has a developmental screening performance measure that is reported annually. Assures developmental evaluations are provided to Medicaid enrolled children 0-3 years. A development evaluation is periodic reviews of a child's development as an integrated part of a well-child examination to include a review of developmental milestones, behavior, family risk factors, and parent concerns. This measure is completely for the Medicaid population and the Expansion population under S-CHIP.

(5) Beginning in March 2007 Iowa Medicaid began a comprehensive approach to improving quality healthcare with a vision to maximize the value of the program to Medicaid members within the fiscal limitations of the state and federal budget. The 3 primary categories of comparison review include a norm for Iowa Medicaid spending, benchmarks for industry standards, and benchmarks for quality. Expert analysis of integrated information was used to formulate recommendations for the Iowa Medicaid program. Recommendations take into consideration: reach, long-term sustainability, operational and administrative implications, projected health outcomes, return on investment, and performance metrics. The project "checklist" supports a systematic review of claims-related information and is reported on monthly to the Department's Director and policy staff. The "checklist" includes the selected performance indicator and rationale for selection, data collected and description and overview of the assessment and analysis, outcomes, actions and recommendations.

X. Quality in Home and Community Based Services Programs

☒ Assessed by CMS?	Number of Waiver Programs: 7 – The Quality Improvement system also includes the State plan Habilitation and Remedial services

Comments:
Over the past several years, Iowa has worked closely with the CMS Regional Office in the course of the waiver renewal process to assure that the State's Quality Improvement plan meets CMS requirements. Iowa has submitted a waiver renewal using the 3.5 version of the waiver application, which requires the State to clearly spell out its quality improvement strategies. The application has been reviewed and approved by CMS.

At the recommendation of CMS regional office, the State has consulted with Beth Jackson of Thompson-Reuters (a CMS contractor on quality) to further develop our quality improvement plan. Iowa will work with Ms. Jackson to craft performance measures to make use of the information and data on quality that the State currently gathers and to articulate the performance measures and improvement strategies to fulfill CMS requirements.

Tab B

Data Reflective of Iowa's Broad Quality Efforts

- Agency for Healthcare Research and Quality 2007 State Snapshot – Iowa (as of April 29, 2008) – See http://statesnapshots.ahrq.gov/snaps07/strongest_weakest.jsp?menuId=6&state=IA and http://statesnapshots.ahrq.gov/snaps07/dashboard.jsp?menuId=4&state=IA&level=0

Iowa

Strongest and Weakest Measures

Iowa's Strongest Measures

Strongest Measures are those in which the State performed above the all-State average and are strongest among their measures relative to all reporting States. This State may be leading the way in quality in these measures.

Note: The best result for each measure can be either the highest or lowest value. The direction representing best is noted in the "Best" column.

Measure Short Name	Measure Long Name	Best
Diabetes eye exams	Percent of adults age 40 and over with diabetes who had a retinal eye examination in the past year	highest
Infant deaths - very low birth weight	Infant deaths per 1,000 live births, birth weight < 1,500 grams	lowest
HIV deaths	HIV-infection deaths per 100,000 population	lowest
Nursing home long-stay residents - with too much weight loss	Percent of long-stay nursing home residents who lose too much weight	lowest
Nursing home long-stay residents - bed/chair bound	Percent of long-stay nursing home residents who spent most of their time in bed or in a chair	lowest

Iowa's Weakest Measures

Weakest Measures are those in which the State performed below the all-State average and are weakest among their measures relative to all reporting States. These measures highlight some of the opportunities for improvement.

Note: The best result for each measure can be either the highest or lowest value. The direction representing best is noted in the "Best" column.

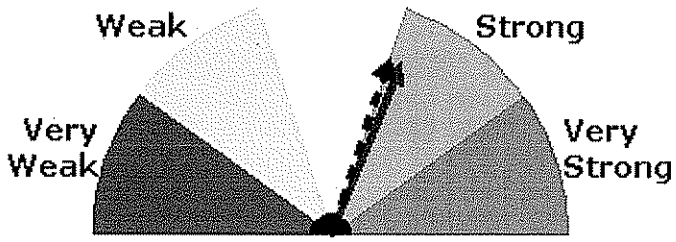
Measure Short Name	Measure Long Name	Best
Home health care - improved oral drug management	Percent of home health care patients who get better at taking their medicines correctly (by mouth)	highest
Home health care - improved mobility	Percent of home health care patients who get better at walking or moving around	highest
Home health care - incontinence	Percent of home health care patients who have less urinary incontinence	highest
Nursing home short-stay residents - with delirium	Percent of short-stay nursing home residents with delirium	lowest
Home health care - plus urgent care	Percent of home health care patients who needed urgent, unplanned medical care	lowest

Iowa

Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality

Average



Performance Meter: All Measures

The meters above and below are summaries of measures reported in the National Healthcare Quality Report (NHQR) for Iowa. The above meter is a summary of over 100 measures in the NHQR reported at the State level, while the 12 meters below describe specific types of care, settings of care, and care in clinical areas.

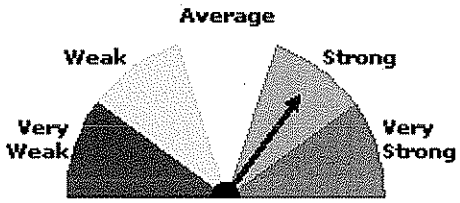
Each meter shows a State's balance of below average, average, and above average measures compared to all States reporting such data in the United States. The performance meter has five categories: very weak, weak, average, strong, and very strong. An arrow pointing to "very weak" means all or nearly all included measures for a State are below average within a given data year. An arrow pointing to "very strong" indicates that all or nearly all available measures for a State are above average within a given data year. A solid arrow describes results for the most recent data year; a dashed arrow describes the baseline year. A missing arrow means there were insufficient data to create the summary measure for this State.

Compared to all States, for the most recent data year, the performance for Iowa for all measures is in the strong range. For the baseline year, performance is in the strong range.

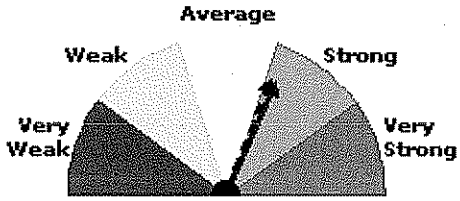
Click on any meter to find the underlying measures.

How are measures represented by a performance meter? (select this link or Methods)

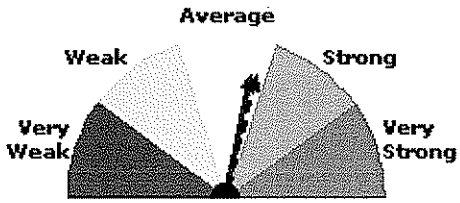
Types of Care



Performance Meter:
Preventive Measures

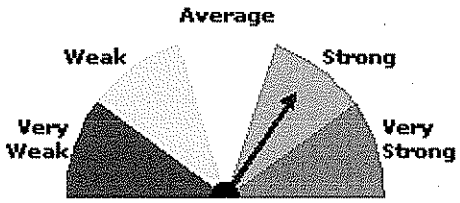


Performance Meter:
Acute Care Measures

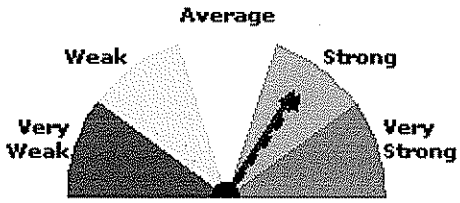


Performance Meter:
Chronic Care Measures

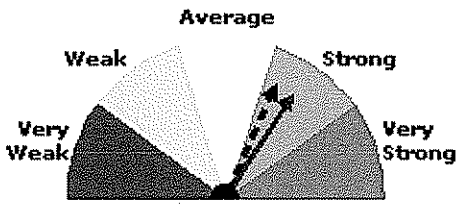
Settings of Care



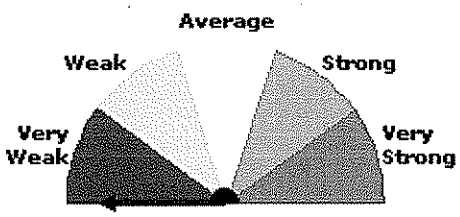
Performance Meter:
Hospital Care Measures



Performance Meter:
Ambulatory Care Measures

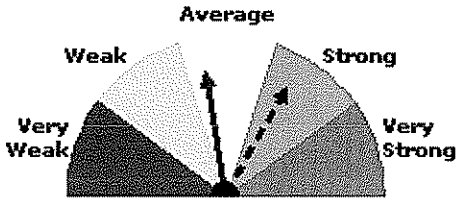


Performance Meter:
Nursing Home Care Measures

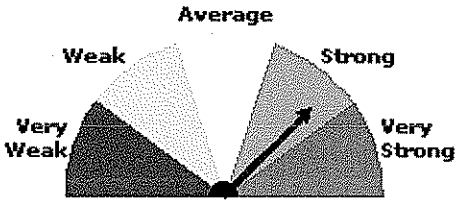


Performance Meter:
Home Health Care Measures

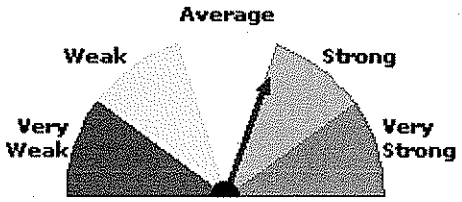
Care by Clinical Area



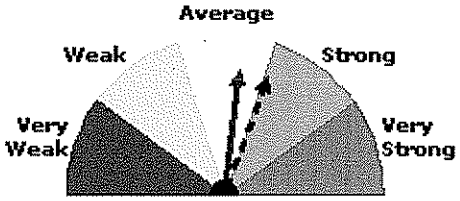
Performance Meter: Cancer Measures



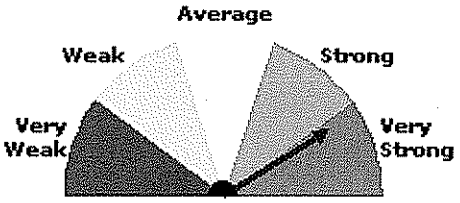
Performance Meter: Diabetes Measures



Performance Meter: Heart Disease Measures



Performance Meter: Maternal and Child Health Measures



Performance Meter: Respiratory Diseases Measures

 = Most Recent Data Year

 = Baseline Year

(Baseline year may vary across measures)

How are measures represented by a performance meter? (select this link or Methods)

Tab C

Data Reflective of Iowa's Quality Efforts Related to Children's Health

CMS Analyses and Initiatives:

- CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program
- CMS Analysis of Immunization Status of Iowa Medicaid Children ages 19 – 35 months
- CMS Childhood Obesity Initiatives

Analyses and Initiatives Developed by Other Organizations:

- Snapshot of Child Health Needs and System Performance: Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (April 13, 2006)
- Maternal and Child Health Bureau – Iowa State Priority Needs
- Title V Maternal and Child Health Block Grant Performance Measures – Iowa

CMS Analyses and Initiatives:

CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program

As part of the State Improvement Package implementing the Medicaid Quality Improvement Program, we are providing an analysis of the most recent submittal of form CMS-416, the EPSDT annual reporting form, for fiscal year 2007 for your State. The following information is noted.

Participation Goal: The State of Iowa's FY 2007 participation ratio is 68%, a decrease of 3% from FY 2006. The national participation goal continues to be 80%.

Dental Services: For FY 2007, the data shows that the State provided some dental service to approximately 43% of eligible EPSDT individuals, an increase of 1% from FY 2006.

Lead Screening: For FY 2007, the data shows the State has provided a lead screening test to just 9% of the eligible EPSDT population under the age of 6 who should have had a screening blood lead test. This is a decrease of 2% from FY 2006. Blood lead screening continues to be a requirement under the federal Medicaid program for all children ages 1 and 2 as well as a blood test for any child under the age of 6 for whom no record of a test is available.

CMS Analyses and Initiatives:

CMS Analysis of Immunization Status of Iowa Medicaid Children ages 19 – 35 months

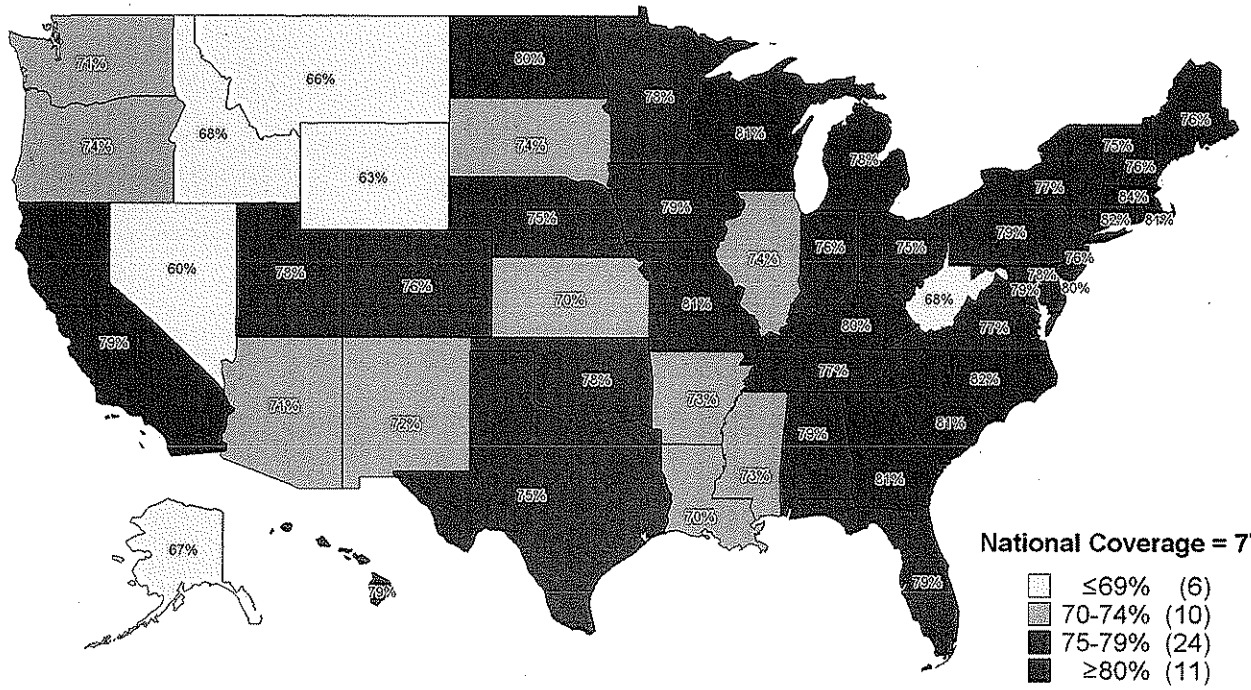
According to Healthy People 2010, the nation's objective for immunization status of children is to increase and maintain the vaccination coverage levels among children age 19 to 35 months. The goal is 90% fully immunized for the nation or any one state. To achieve herd immunity, a population must reach a goal of at least 80% of a population to be fully immunized to prevent outbreak of a vaccine preventable disease.

One way to measure the effort of a population is through the National Immunization Survey (NIS). The NIS is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The NIS is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers that began data collection in April 1994 to monitor childhood immunization coverage.

The target population for the NIS is children between the ages of 19 and 35 months living in the United States at the time of the interview. Data from the NIS are used to produce timely estimates of vaccination coverage rates for all childhood vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP). Estimates are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. The official estimates of vaccination coverage rates from the NIS are rates of being up-to-date with respect to the ACIP recommended numbers of doses of vaccines. Vaccinations included in the survey are: 4 diphtheria and tetanus toxoids, and acellular pertussis vaccine (DTaP); 3 poliovirus vaccine (polio); 1 measles-containing vaccine (MCV); 3 Haemophilus influenzae type b vaccine (Hib); 3 hepatitis B vaccine (Hep B); 1 varicella zoster vaccine for the series plus pneumococcal conjugate vaccine (PCV), 3 hepatitis A vaccine (Hep A), and influenza vaccine (FLU) included in the single vaccination rates reported. The series is referred to as 4:3:1:3:3:1. This is the measure most States use to report their HEDIS measures.

Iowa's overall rate for 2006 is 78.9% with a national average of 77.5%. The number of Medicaid children was not specifically measured but the number of children in the Vaccines for Children Program (VFC) in Iowa with full immunizations was 77.0% with a national VFC coverage rate of 79.8%. The majority of VFC participants are Medicaid children and is the primary source of Medicaid immunizations. More information may be obtained at http://cdc.gov/nis/ .

4:3:1:3:3:1* Series Coverage: Children 19-35 Months, 2006



Note 1: *4+DTP, 3+Polio, 1+MMR, 3+HIB, 3+HepB, 1+Varicella
Note 2: Includes children born between 01/06/2003 and 07/18/2005
Source: National Immunization Survey (NIS)
Revised April 2008

CMS Analyses and Initiatives:

CMS Childhood Obesity Initiatives

Background Information

- One of the national health objectives for 2010 is to reduce the prevalence of overweight or obesity (BMI equal to or > than 95th percentile) among children aged 6-19 years from the NHANES III baseline of 11 percent.

- Currently the percentage of young people who are overweight/obese has more than tripled since 1980 and estimated to be over 9 million young people (CDC and AAP)

- Obesity Trends
  - In 1991 four states had obesity prevalence rates of 15-19 percent and no states had rates at or above 20 percent (BMI > 30 or ~ 30 lbs overweight for a 5'4" person)
  - In 1995, obesity prevalence in each of the 50 states was less than 20 percent.
  - In 2000, 28 states had obesity prevalence rates less than 20 percent
  - In 2005 only 4 states had obesity prevalence rates less than 20 percent; 17 states had rates equal to or > 25 %; 3 of those equal to or > 30%

- Obesity Data
  - Recent data indicates prevalence of overweight children 6-11 years has quadrupled, from 4 percent to 16 percent.
  - The prevalence among adolescents aged 12 -19 years increased more than three-fold from approximately 5 percent to 16 percent.
  - Among boys, prevalence was significantly higher among Mexican Americans (25.5%) than non-Hispanic blacks (17.9%) or non-Hispanic whites (14.3%)
  - Among girls, the prevalence was significantly lower among non-Hispanic whites (12.9%) than non-Hispanic blacks (23.2%) or Mexican Americans (18.5%)

- Cost to the Nation
  - Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.
  - Annual healthcare costs are about $6,700 for children treated for obesity covered by Medicaid and $3,700 billion for obese children with private insurance.
  - Children with obesity are roughly three times more expensive for the health system than the average insured child.

- Total healthcare spending for children who receive a diagnosis of obesity is approximately $280 million per year for those with private insurance and $470 million for those with Medicaid.
- Children diagnosed with obesity are two to three times more likely to be hospitalized.
- Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance.
- Obesity-associated annual hospital costs for children and youth more than tripled over 2 decades: from $35 million in 1979-1981 to $127 million in 1997-1999 (IOM)

- Medicaid Coverage and Reimbursement - Obesity related services can include:

  - Inpatient and outpatient hospital services, physician services (including medical visits and surgery) and clinic services.
  - Other licensed practitioners: States may elect to provide this optional benefit to include any medical and remedial care, other than a physician, such as licensed nutritionists, practicing with their scope of practice.
  - Obesity related services may also be covered as preventive services for individuals not eligible for EPSDT services. Such services must be provided by a physician or other licensed practitioner and provided when necessary to prevent disease, disability and other health conditions or their progression; prolong life; or promote physical and mental health and efficiency.
  - States are required to determine medical necessity for obesity related services.
  - States set their own reimbursement rates for services. Rates must be sufficient to enlist enough providers of services at least to the extent the services are available to the general population

Data Specific to the State of Iowa

The State ranks sixth best among all States in percentage of children ages 10-17 who are considered overweight or obese according to Body Mass Index-for-age standards. The State's overall prevalence of childhood obesity is about five percentage points lower than the national average. The percentage of overweight or obese children is comparable to national averages for children in low-income families and those covered by public insurance.

Iowa's Childhood Obesity Action Network report card is available at http://childhealthdata.org/content/ObesityReportCards.aspx

Analyses and Initiatives Developed by Other Organizations:

Snapshot of Child Health Needs and System Performance:

Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (June 15, 2006)

Data Resource Center for Child & Adolescent Health

Your Data... Your story

Snapshot of Child Health Needs and System Performance:
Findings from the National Survey of Children with Special Health Care Needs
and the National Survey of Children's Health
June 15, 2006

Prepared by:
Child and Adolescent Health Care Initiative (CAHMI)
Data Resource Center for Child and Adolescent Health

Introduction

This report presents state-specific summaries of findings from two national surveys of children's health, highlighting 20 **Child Health Needs and Outcomes** measures and 25 measures of **Health System Performance and Improvement Opportunities**. These indicators were selected based on their relevance to Medicaid quality of care strategies and requirements for children and adolescents and are also relevant to several Healthy People 2010 objectives, including improving access to comprehensive, high-quality health care services and ensuring children with special health care needs (CSHCN) have a "Medical Home", as defined by the American Academy of Pediatrics.

Additional state specific data on the indicators represented are available on the online Data Resource Center for Child and Adolescent Health (DRC) at www.childhealthdata.org. This website delivers point-and-click, hands-on access to national, state, and regional data from the NSCH and the NS-CSHCN and downloadable, "print-and-go" data tables and graphs as well as easy-to-understand information about survey content and methods. The DRC features an easy-to-use interactive search feature that allows users to select, view, compare, and download results for every state and HRSA region and iteratively compare states and subgroups of children within and across each state (e.g. child's age, race, household income, insurance status and type, health status, family structure, etc.). The Data Resource Center is a project of the Child and Adolescent Health Measurement Initiative (CAHMI) in partnership with state and family leaders and is sponsored by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health & Human Services.

Data Sources

Data represented in the state data reports are from the most recent National Survey of Children with Special Health Care Needs (NS-CSHCN, 2001) and National Survey of Children's Health (NSCH, 2003). Both surveys were sponsored by the Maternal and Child Health Bureau and administered by the National Center for Health Statistics. The survey data was collected by means of computer assisted telephone interviews (CATI) with parents from randomly selected households throughout the nation.

The NSCH collected data on 102,353 children between the ages of 0-17 years, approximately 2000 per state (ranging from 1,483 – 2,241). The survey covers a wide range of topics, including children's physical and mental health and risk status, health insurance status and type of coverage, access to and use of health care services, medical home, additional age-specific information (0-5 years and 6-17 years), family health and activities, parents' health status, and more. This survey will be repeated in 2007.

The NS-CSHCN screened 372,174 children nationally to identify those with special health care needs (using the CAHMI CSHCN Screener) who received a more in-depth interview. In each state, 750 CSHCN were selected for the longer, more detailed CSHCN interview, resulting in a total of 38,866 CSHCN interviews. Survey topics include health and functional status of the child, type and adequacy of the child's health insurance coverage, access to health care, care coordination, family-centeredness of child's health care, and impact of child's health on family. This survey was repeated in 2005-2006 and will be available in late 2007.

The data in both surveys is based on parent report for a selected child within the household. The data is weighted to adjust for sampling error and was analyzed to adjust variance estimates for complex sampling methods. Data was also post-stratified to represent all children and youth age 0-17 nationally and in each state. Unknown values ("don't know", "refused") were treated as missing. Table 1 below provides summary statistics of the characteristics of children upon which regional and national findings are based. Similar statistics for individual states may be obtained on the DRC website.

Indicators

State results tables for each survey list indicators in two groups: (1) **Child Health Needs and Outcomes**, and (2) **System Performance and Improvement Opportunities**. The indicators reported here were developed for use in the DRC using a multi-step process involving extensive technical, statistical, policy, and family input. Many are also included in national child health chartbooks produced and disseminated by the federal Health Resources and Services Administration's Maternal and Child Health Bureau as well as by some states. Details about the surveys and documentation of the indicators may be accessed on the DRC website, www.childhealthdata.org.

Indicator results for each state are displayed in two one-page tables for each state in the CMS region. One table presents findings based on indicators from the NS-CSHCN and one for the NSCH. The NSCH table shows results for all non-institutionalized children ages 0-17 years. Results in the NS-CSHCN table apply ONLY to children with special health care needs (CSHCN). The title for each indicator describes the population that was queried (the denominator) and the relevant responses (the numerator). Specifically, some of the indicators apply only to certain age groups.

For each indicator, separate prevalence estimates are given for children whose parent or guardian reported that they had public insurance and for those reporting that the child had private sector insurance coverage. Within the two insurance groups, results are shown for the state, HRSA region and nation. For each indicator, population prevalence estimates are shown. In smaller type, the 95% confidence interval (CI) for that estimate is also displayed. This is the range within which the actual prevalence can be assumed to fall after taking into account possible sampling error. Results for children who were uninsured are not shown. For the NS-CSHCN data, children who had a combination of public and private insurance are also not shown in these reports. Tables that include these groups may be obtained from the DRC website.

Presentation of the indicators and results reflect their format in the DRC website, and the Indicator and Outcome numbers are the same as shown on the DRC website. Because desirable results may be reflected by either high or low prevalence rates, it is important to read the text of the indicator carefully. Most often higher rates reflect "better" health or performance. However, for several indicators higher rates represent higher levels of need or "lower" performance.

Resources and References

1. American Academy Of Pediatrics, "The Medical Home: Medical Home Initiatives for Children With Special Needs Project Advisory Committee," Pediatrics Vol. 110 No. 1 July 2002, pp. 184-186
2. Blumberg SJ, Olson L, Frankel M, et al. 2003. "Design and operation of the National Survey of Children with Special Health Care Needs 2001," Vital Health Statistics 1(41).
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5. Child and Adolescent Health Measurement Initiative (CAHMI). Data Resource Center on Child and Adolescent Health, www.childhealthdata.org.
6. Child and Adolescent Health Measurement Initiative (2005). *National Survey of Children's Health*, Data Resource Center on Child and Adolescent Health website, www.nschdata.org.
7. Child and Adolescent Health Measurement Initiative (2005). *National Survey of Children' with Special Health Care Needs*, Data Resource Center on Child and Adolescent Health website, www.cshcndata.org.
8. Federal Register. June 14, 2002. Centers for Medicare and Medicaid Services. Medicaid program, Medicaid managed care; Final rules, Vol. 67, No. 115, p. 40988-41116.
9. U.S. Department of Health and Human Services (HHS) 2000. Healthy People 2010, 2nd edition, with "Understanding and improving health" and "Objectives for improving health," 2 vols. Washington, DC: Government Printing Office.

National Survey of Children 's Health

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Child Health Indicators by Insurance Type

	Public Insurance			Private Insurance		
	Iowa	HRSA Region VII	National	Iowa	HRSA Region VII	National
Health Needs and Outcomes						
Indicator 1.1: % ages 0-17 whose overall health is excellent or very good	84.3% 79.7% - 88.9%	78.7% 76.0% - 81.4%	73.3% 72.3% - 74.4%	90.1% 88.3% - 91.9%	91.4% 90.5% - 92.3%	90.7% 90.3% - 91.1%
Indicator 1.2: % ages 1-17 whose teeth are in excellent or very good condition	62.5% 55.7% - 69.3%	63.0% 59.6% - 66.3%	56.4% 55.2% - 57.6%	76.8% 74.3% - 79.4%	77.7% 76.4% - 79.1%	76.3% 75.7% - 76.9%
Indicator 1.3: % ages 0-5 who were breastfed for any length of time	48.6% 38.3% - 58.8%	55.7% 50.3% - 61.2%	63.3% 61.7% - 65.0%	70.3% 65.3% - 75.2%	75.3% 72.8% - 77.8%	77.3% 76.3% - 78.2%
Indicator 1.4: % ages 10-17 who are within normal weight range for their age and height	56.0% 44.9% - 67.2%	54.1% 48.9% - 59.4%	55.9% 54.1% - 57.8%	72.1% 68.6% - 75.7%	70.3% 68.3% - 72.3%	68.2% 67.3% - 69.1%
Indicator 1.5: % ages 6-17 who exercised 4 or more days in the last week	59.1% 50.2% - 68.0%	58.7% 54.5% - 62.9%	57.6% 56.1% - 59.1%	61.4% 58.1% - 64.7%	62.6% 60.8% - 64.4%	60.1% 59.3% - 60.8%
Indicator 1.6: % school age children who missed 11 or more days of school in the past year due to illness or injury	6.4% 2.7% - 10.0%	7.9% 5.6% - 10.2%	8.1% 7.3% - 8.8%	4.6% 3.0% - 6.1%	3.9% 3.2% - 4.7%	4.2% 3.9% - 4.5%
Indicator 1.7: % ages 0-5 with injuries requiring medical attention during past year	8.4% 3.5% - 13.4%	9.6% 6.4% - 12.7%	9.1% 8.0% - 10.1%	13.0% 9.2% - 16.8%	10.4% 8.6% - 12.1%	10.0% 9.3% - 10.6%
Indicator 1.10: % ages 0-17 affected by asthma during past year	6.2% 3.2% - 9.3%	11.2% 9.1% - 13.3%	10.8% 10.0% - 11.5%	6.1% 4.8% - 7.5%	7.0% 6.2% - 7.8%	7.3% 7.0% - 7.7%
Indicator 2.1: % ages 0-5 whose parents have one or more concerns about child's learning, development, or behavior	49.3% 39.0% - 59.6%	42.4% 37.1% - 47.7%	42.2% 40.4% - 44.0%	32.5% 27.6% - 37.5%	30.4% 27.8% - 33.1%	33.2% 32.1% - 34.3%
Indicator 2.2: % ages 1-5 who are at moderate/high risk for developmental delay	37.2% 25.8% - 48.6%	28.5% 23.0% - 34.0%	30.1% 28.2% - 31.9%	21.7% 16.9% - 26.6%	20.7% 18.2% - 23.3%	21.6% 20.6% - 22.6%
Indicator 2.3: % ages 3-17 with moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others	15.6% 9.7% - 21.6%	17.6% 14.9% - 20.4%	14.9% 14.0% - 15.8%	5.4% 3.9% - 6.8%	6.0% 5.2% - 6.8%	7.0% 6.6% - 7.3%
Indicator 2.7: % ages 2-17, ever told have ADD/ADHD, currently taking medication for ADD/ADHD	11.4% 6.0% - 16.8%	7.9% 6.1% - 9.7%	5.2% 4.7% - 5.7%	3.8% 2.7% - 5.0%	3.4% 2.8% - 3.9%	3.6% 3.4% - 3.9%
Indicator 6.3: % ages 0-17 whose mother's overall physical and mental health is excellent or very good	45.9% 39.0% - 52.8%	44.2% 40.7% - 47.6%	42.1% 40.9% - 43.3%	70.7% 68.0% - 73.4%	70.1% 68.6% - 71.6%	68.3% 67.7% - 68.9%
Performance and Improvement Opportunities						
Indicator 3.2: % ages 0-17 currently uninsured or not insured for some period during the past year	12.8% 8.6% - 17.0%	11.2% 9.1% - 13.3%	12.9% 12.2% - 13.7%	3.6% 2.5% - 4.7%	3.5% 2.9% - 4.1%	4.0% 3.8% - 4.3%
Indicator 4.1: % ages 0-17 with a preventive medical care visit in the past year	79.4% 74.1% - 84.8%	81.4% 78.9% - 83.9%	79.8% 78.8% - 80.7%	77.4% 75.0% - 79.8%	77.3% 76.0% - 78.6%	79.8% 79.3% - 80.3%
Indicator 4.3: % ages 0-17 with both a preventive medical care visit and a preventive dental care visit in the past year	59.5% 52.7% - 66.2%	53.6% 50.3% - 56.9%	55.8% 54.6% - 57.0%	63.7% 61.0% - 66.5%	62.2% 60.6% - 63.7%	63.4% 62.8% - 64.1%
Indicator 4.5: % ages 1-17 with current emotional, developmental, or behavioral problems who received some type of mental health care during the past year	82.0% 69.9% - 94.1%	69.5% 61.3% - 77.8%	58.6% 54.9% - 62.3%	55.9% 41.2% - 70.6%	61.5% 53.7% - 69.3%	63.2% 60.4% - 66.0%
Indicator 4.8: % ages 0-17 whose medical care meets all six Medical Home criteria	49.8% 43.1% - 56.5%	43.6% 40.4% - 46.9%	38.9% 37.7% - 40.0%	53.5% 50.7% - 56.4%	53.0% 51.5% - 54.6%	52.6% 52.0% - 53.3%
Indicator 4.9: % ages 0-17 who have a personal doctor or nurse (PDN)	88.1% 84.2% - 92.0%	82.7% 80.1% - 85.3%	78.0% 77.0% - 79.0%	90.8% 89.1% - 92.5%	90.9% 90.0% - 91.8%	89.5% 89.1% - 89.9%
Indicator 4.10: % ages 0-17 who have a personal doctor or nurse who usually or always spends enough time and explains things well	66.0% 59.7% - 72.4%	61.0% 57.8% - 64.3%	54.6% 53.5% - 55.8%	78.1% 75.8% - 80.5%	77.7% 76.4% - 79.0%	74.7% 74.1% - 75.3%
Indicator 4.12: % ages 0-17 who have a PDN and needed specialized care or services and had few or no problems getting them	87.5% 78.7% - 96.3%	82.9% 78.1% - 87.7%	78.3% 76.3% - 80.3%	90.9% 87.3% - 94.5%	90.6% 88.8% - 92.5%	87.4% 86.6% - 88.3%
Indicator 4.13: % ages 0-17 who have a PDN and got specialized care or services, whose PDN usually or always follows up with them	74.4% 64.4% - 84.4%	62.9% 56.8% - 69.0%	62.6% 60.4% - 64.9%	61.8% 56.1% - 67.5%	55.6% 52.6% - 58.7%	55.8% 54.6% - 57.0%
Indicator 4.14: % ages 0-5 who had a doctor visit during which the doctor asked if parents have concerns about the child's learning, development or behavior	36.2% 26.5% - 46.0%	34.7% 29.6% - 39.9%	32.4% 30.7% - 34.0%	45.2% 39.9% - 50.5%	45.6% 42.7% - 48.4%	42.4% 41.2% - 43.5%
Indicator 6.4: % ages 0-17 who live in households where someone smokes	51.5% 44.2% - 58.8%	48.9% 45.3% - 52.5%	38.4% 37.2% - 39.6%	28.9% 26.1% - 31.7%	27.7% 26.2% - 29.2%	25.1% 24.5% - 25.7%
Indicator 6.7: % ages 0-5 who were read aloud to by family members every day during the past week	51.2% 40.9% - 61.4%	44.2% 38.9% - 49.5%	41.4% 39.6% - 43.1%	54.2% 48.9% - 59.4%	52.4% 49.6% - 55.3%	52.7% 51.5% - 53.8%

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Child and Adolescent Health Measurement Initiative, 2003 National Survey of Children's Health, Data Resource Center on Child and Adolescent Health, www.nschdata.org. March 2006

National Survey of Children with Special Health Care Needs
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Child Health Indicators by Insurance Type

	Public Insurance			Private Insurance		
	Iowa	HRSA Region VII	National	Iowa	HRSA Region VI	National
Health Needs and Outcomes Indicator #1: % of CYSHCN ages 0-17 whose health conditions consistently and often greatly affect their daily activities	20.9% 13.5% - 28.4%	35.2% 30.0% - 40.3%	35.6% 33.5% - 37.7%	11.8% 8.5% - 15.0%	13.7% 12.1% - 15.4%	16.6% 15.7% - 17.5%
Prescription Medications: % of CYSHCN ages 0-17 who met screening criteria for prescription medication use for an ongoing condition	74.7% 66.6% - 82.9%	72.2% 67.7% - 76.7%	69.5% 67.4% - 71.5%	82.4% 78.3% - 86.5%	82.1% 80.2% - 84.1%	78.8% 77.8% - 79.8%
Service Use: % of CYSHCN ages 0-17 who met screening criteria for elevated use of medical or related services for an ongoing condition	54.3% 44.3% - 64.2%	54.5% 49.6% - 59.4%	54.7% 52.6% - 56.9%	37.6% 32.6% - 42.6%	40.5% 38.2% - 42.9%	41.0% 39.9% - 42.1%
Specialized Therapies: % of CYSHCN ages 0-17 who met screening criteria for specialized therapies for an ongoing condition	11.9% 6.2% - 17.7%	19.6% 15.9% - 23.3%	23.3% 21.5% - 25.0%	7.4% 4.8% - 10.0%	10.7% 9.2% - 12.2%	13.0% 12.2% - 13.7%
Mental Health: % of CYSHCN ages 0-17 who met screening criteria for ongoing emotional, developmental or behavioral conditions	40.8% 30.9% - 50.7%	41.4% 36.5% - 46.3%	40.4% 38.2% - 42.5%	22.5% 17.9% - 27.2%	20.0% 18.0% - 21.9%	22.4% 21.4% - 23.4%
Functional Limitations: % of CYSHCN ages 0-17 who met screening criteria for functional limitations due to ongoing condition	23.9% 15.6% - 32.1%	28.4% 23.7% - 33.1%	27.9% 26.2% - 29.7%	12.5% 9.3% - 15.6%	14.2% 12.6% - 15.9%	17.0% 16.1% - 17.8%
Indicator #2: % of CYSHCN ages 5-17 with 11 or more days of school absences due to illness	23.5% 13.4% - 33.6%	22.9% 18.1% - 27.7%	23.3% 21.2% - 25.5%	8.3% 5.4% - 11.2%	9.3% 7.9% - 10.8%	12.4% 11.6% - 13.3%
Performance and Improvement Opportunities Indicator #5: % of currently insured CYSHCN ages 0-17 with health insurance coverage that is not adequate	29.7% 20.0% - 39.5%	31.3% 26.2% - 36.4%	37.6% 35.5% - 39.8%	25.3% 20.9% - 29.8%	29.2% 27.1% - 31.4%	31.7% 30.7% - 32.8%
Indicator #6: % of CYSHCN ages 0-17 with one or more unmet needs for specific health care services	15.3% 7.4% - 23.2%	24.3% 19.4% - 29.3%	25.2% 23.2% - 27.2%	7.7% 5.1% - 10.3%	10.0% 8.6% - 11.5%	12.2% 11.4% - 13.1%
Indicator #7b: % of CYSHCN ages 0-17 whose families were not able to get all the family support services they needed	18.2% 4.2% - 32.1%	29.3% 19.3% - 39.2%	23.3% 20.1% - 26.5%	11.1% 3.3% - 18.8%	20.7% 15.2% - 26.2%	18.7% 16.5% - 20.9%
Indicator #8: % of CYSHCN ages 0-17 who had problems getting referrals for specialty care	13.2% 3.7% - 22.7%	19.1% 13.6% - 24.5%	28.3% 25.5% - 31.1%	10.4% 5.3% - 15.6%	14.4% 12.0% - 16.7%	18.9% 17.6% - 20.1%
Indicator #9: % of CYSHCN ages 0-17 without a usual source of care or who rely on the emergency room	14.5% 7.1% - 22.0%	10.5% 7.9% - 13.1%	10.4% 9.1% - 11.7%	12.3% 8.5% - 16.0%	8.2% 6.9% - 9.5%	7.9% 7.3% - 8.4%
Indicator #10: % of CYSHCN ages 0-17 without a personal doctor or nurse	10.4% 5.0% - 15.8%	10.4% 7.4% - 13.3%	14.7% 13.0% - 16.4%	6.4% 3.9% - 8.8%	5.6% 4.5% - 6.6%	8.6% 7.9% - 9.3%
Indicator #11: % of CYSHCN ages 0-17 who had one or more doctor visits but did not have family-centered care	36.8% 26.7% - 46.9%	40.0% 35.0% - 45.0%	42.6% 40.4% - 44.8%	25.1% 20.3% - 29.9%	26.1% 23.8% - 28.3%	27.6% 26.5% - 28.6%
Indicator #13: % of CYSHCN ages 0-17 whose families experienced financial problems due to child's health needs	14.4% 8.0% - 20.9%	24.7% 19.9% - 29.5%	24.4% 22.5% - 26.4%	17.9% 13.7% - 22.0%	17.2% 15.3% - 19.1%	16.6% 15.8% - 17.5%
Indicator #15: % of CYSHCN ages 0-17 whose family members cut back and/or stopped working because of child's health needs	35.1% 25.2% - 45.0%	40.2% 35.2% - 45.2%	41.4% 39.3% - 43.6%	16.5% 12.6% - 20.4%	19.8% 17.8% - 21.7%	23.3% 22.3% - 24.3%
MCHB #1: % of CYSHCN ages 0-17 whose families are partners in decision-making and are satisfied with the services they receive	41.2% 26.4% - 56.1%	48.9% 42.0% - 55.8%	49.4% 45.9% - 53.0%	67.2% 60.7% - 73.8%	64.5% 61.2% - 67.8%	62.9% 61.1% - 64.6%
MCHB #2: % of CYSHCN ages 0-17 who received coordinated, ongoing, comprehensive care within a medical home	48.9% 38.6% - 59.3%	48.1% 43.2% - 53.1%	43.8% 41.6% - 46.0%	61.4% 56.2% - 66.6%	62.1% 59.7% - 64.5%	58.1% 56.9% - 59.3%
MCHB #3: % of CYSHCN ages 0-17 who have adequate insurance to pay for the services they need	57.2% 46.6% - 67.7%	62.1% 57.1% - 67.0%	55.3% 53.1% - 57.5%	72.6% 68.0% - 77.2%	69.4% 67.2% - 71.7%	66.4% 65.3% - 67.5%

Child and Adolescent Health Measurement Initiative, 2001 National Survey of Children with Special Health Care Needs, Data Resource Center on Child and Adolescent Health, www.cshcndata.org, March 2006

Maternal and Child Health Bureau

State Priority Needs

Title V legislation directs States to conduct a Statewide maternal and child health needs assessment every 5 years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and children with special health care needs. From this assessment, States select 7 to 10 priorities for focused programmatic efforts over the succeeding 5 years. States may adjust their priorities during the interim years as needs change.

State	Priority Need	Keywords	Population/Race
Iowa	Improve the quality of family support and parenting education programs and services	Health Promotion, Family Support Service, Quality Assurance	Families
Iowa	Assure children enrolled in early care and education programs are in quality environments.	Quality Assurance, Child Care	Children (1 through 21), Infants
Iowa	Assure developmental evaluations are provided to Medicaid enrolled children 0-3 years.	Primary/Preventive Health Care, Quality Assurance, Health Screening	Children (1 through 21), Infants, Newborns
Iowa	Assure access to pediatric specialty care for all children.	Access to Health Care, Specialized Care	Children (1 through 21), Infants, Newborns
Iowa	Minimize developmental delay through early intervention services for children 0-3 years.	Access to Health Care, Primary/Preventive Health Care, Mental Health, Health Screening	Children (1 through 21), Infants, Newborns
Iowa	All children and adolescents should be physically active for at least 30 minutes, limit screen time to no more than two hours, and eat five or more servings of fruits and vegetables each day.	Nutrition/Physical Activity	Adolescents (10 through 19), Children (1 through 21)
Iowa	Improve the quality of primary care for children in Iowa.	Primary/Preventive Health Care, Quality Assurance	Children (1 through 21), Infants, Newborns
Iowa	Assure access to oral health care for children in Iowa.	Oral Health, Access to Health Care	Children (1 through 21)
Iowa	Reduce infant mortality.	Birth Outcomes,	Infants,

		Morbidity/Mortality	Newborns
Iowa	Assure pregnant and parenting women are screened and referred to appropriate mental health services.	Primary/Preventive Health Care, Mental Health, Health Screening, Specialized Care	Pregnant Women, Mothers

Title V Maternal and Child Health Block Grant
Performance Measures – Iowa

Each State reports on 7 to 10 State Performance Measures that they develop and have approved by the Maternal and Child Health Bureau (MCHB). This procedure allows States to measure progress toward goals that are specific to a State. Each Measure in this table is linked to a detailed description of the Performance measure. The data below were reported by States in their Title V Block Grant FY2006 Annual Report and FY 2008 Application; Form 16.

The information on Performance Measures provided below can also be found at
https://perfdata.hrsa.gov/mchb/mchreports/Search/neg/negsch02p.asp
All 2006 indicators we reported by States in their Title V Block Grant FY2006 Annual Report and FY 2008 Application; Form 16.

State Performance Measure #1

Percent of children served by family support programs, whose primary delivery method is a home visit, that are served through evidence-based programs. The goal is to increase the percent of Community Empowerment Areas that fund evidenced-based family support and parent education programs. Iowa is currently developing evidenced based criteria for Community Empowerment Areas. The data source is the Family Support Environmental Scan.

	2006	2007	2008	2009	2010	2011
Indicator	49.8					
Objective	12	55	60	65	68	70

State Performance Measure #2

Measures the number of early care and education providers who receive child care nurse consultant training or services. The goal is to improve the quality of health and safety in early care and education by increasing the number of early care and education providers receiving child care nurse consultant services. Through the Healthy Child Care Iowa Campaign, child care nurse consultants offer training and technical assistance to early learning providers. The data source is Healthy Child Care Iowa Encounter Data Child Care Resource and Referral Data. Early care and education providers are responsible for the well-being of children enrolled in their facility. The health and safety of children enrolled is a prime concern. Early care and education providers need accessible health care professionals as partners to improve the health and safety components of their business. Child care nurse consultants delivering direct services (on-site consultation, face-to-face services and training) to early care and education providers help providers improve the health and safety components.

	2006	2007	2008	2009	2010	2011
Indicator	1717					
Objective	1224	1750	1800	1850	1900	1950

State Performance Measure #3

Percent of Medicaid enrolled children 0-3 years who receive developmental evaluations. The goal is to assure developmental evaluations are provided to Medicaid enrolled children 0-3 years. A development evaluation is periodic reviews of a child's development as an integrated part of a well-child examination to include a review of developmental milestones, behavior, family risk factors, and parent concerns. This intervention is to identify and increase the proportion of children with mental health problems who receive treatment. The data source is the HCFA 4.16 Report Medicaid claims data: Fee for Service and

Encounter data. The significance of this performance measure is that behavioral, mental health, and social-emotional problems in children have gained increasing attention and priority in the national and state public health systems in the last several years. Recent studies indicate that 12 percent to 16 percent of children experience developmental problems, but that only one-third of those children are identified in pediatric practices prior to school entry. Using state and local collaborative relationships, Iowa's Title V program has the opportunity to foster the development of a seamless and comprehensive system of screening, assessment, and referral services.

	2006	2007	2008	2009	2010	2011
Indicator	10					
Objective	7	10	12	15	20	25

State Performance Measure #4

Measuring the percent of children who need care from a specialist and who receive the care without problem. The goal is to assure access to pediatric specialty care for all children. The data source is Iowa Child and Family Household Health Survey conducted by the Iowa Department of Public Health, Child Health Specialty Clinics, and University of Iowa Public Policy Center. Data Issues: The data for this performance measure is based on parent report of "need" and "problem" meeting the need. There are no descriptors offered to parent survey respondents to help standardize the concepts of "need" or "problem." That the survey uses a population-based, random sample design strengthens the assumption that the responses are a valid, unbiased representation of family experience. Specialty care is one essential component of a comprehensive system of care for all children. Concepts of systems, medical home, and collaborative partnership manifest prominently in discussions of quality improvement and cost-effectiveness. With estimates ranging as high as 30 percent of all children having a need at some time for specialty care, access to specialists is naturally a relevant concern. Geographical inaccessibility and higher cost of specialty care remain formidable problems.

	2006	2007	2008	2009	2010	2011
Indicator	85.1					
Objective	87	88	89	90	91	92

State Performance Measure #5

Measures the percent of children 0-3 years served by Early ACCESS (IDEA, Part C). The goal is to minimize developmental delay through early intervention services for children 0-3 years. The qualifying definition is that Early ACCESS serves children 0-3 years with a development delay of 25% or greater or a risk of development delays. The data source is Early ACCESS data - OSEP -- OSEP recommends that EA serve 2% of children 0-3 years of age and 1% of children 0-1. A future indicator will be the success with which premature infants and children with other qualifying health conditions are served by Early ACCESS. EA data cannot currently differentiate the condition for which the child was enrolled, but that may be a possibility in the future. The significance of this measure is for CHSC and the IDPH continue close collaboration with Early ACCESS to improve the early intervention system for children 0-3. Research has shown that for children with or at-risk for developmental delay, the earlier that intervention can be provided, the greater chance for the child's improved outcomes. By providing early intervention services to the child and family at the earliest possible time, potential later costs to society can be reduced.

	2006	2007	2008	2009	2010	2011
Indicator	2.7					
Objective	2.4	2.8	2.9	3	3.1	3.2

State Performance Measure #6

Measures the number of Iowa counties that have at least one participating targeted community in the CDC nutrition and physical activity obesity prevention project. The goal is to improve physical fitness of children and adolescents by achieving the following: 1. Seventy-five percent of Iowa children and adolescents in targeted communities will be physically active for 30 minutes daily and moderately active for 60 minutes daily by January 2010. 2. Seventy-five percent of Iowa children and adolescents in targeted communities will limit screen time to no more than two hours daily by January 2010. 3. Seventy-five percent of Iowa children and adolescents in targeted counties participating in the Fit for Life target interventions. The data source will be the evaluation component of the CDC nutrition and physical activity obesity prevention grant. This information will be collected in the targeted communities. According to the "2002 CDC Pediatric Nutrition Surveillance System," 30 percent of low-income children aged 2-5 years in Iowa are overweight or at risk of becoming overweight and 61 percent of Iowa adults are overweight or obese. In Iowa, the obesity rate in adults has increased by 70 percent from 1990 to 2002.

Tab D

CMS Comments on the
Iowa's 2007 Quality Strategy

CMS Response to Iowa's 2007 Quality Assessment & Improvement Strategy

8/27/08

CMS strives to work in partnership with States to fulfill the aims of safe, effective, timely, equitable, efficient, and person-centered care. The State's Quality Assessment & Improvement Strategy is one method of coordinating efforts to achieve these aims. Feedback provided here is intended for consideration in the next revision of the State's Quality Assessment & Improvement Strategy.

A state's Quality Assessment & Improvement Strategy should have, at a minimum, two basic purposes:

(1) to ensure compliance with federal and state statutory and regulatory requirements on quality and

(2) to go beyond compliance with the minimum regulatory requirements by implementing multiple methods for "continuous quality improvement" in order to raise the quality of care provided to, and received by, Medicaid beneficiaries in the state.

Attached to this response are two checklists which the Division of Quality, Evaluation, and Health Outcomes uses in its review of State Quality Strategies. One is entitled the "CMS Review List" (Appendix B) which we use to check your Quality Strategy for compliance with the regulations in 42 CFR 438, Subpart D (the "regulatory checklist") and the other is entitled "Components to Address in a Quality Assessment" (Appendix C) (the "quality checklist"). In general, you will find regulatory issues in the "Code of Federal Regulations" section of this report and the quality issues listed under "Specific Comments on the Quality Strategy". In these sections, we will reference the applicable checklist section for you to review. We do this so that the process of review can be transparent to the States.

One might well ask why the checklists are not combined. They could be, but we chose to separate them because we are doing two separate things in the review. In the first case, we are simply asking whether your Quality Strategy meets the minimal requirements set forth in the regulations. But the second checklist is really intended to ask a larger question, which is the question of whether your State has put into place a real strategy intended to produce continuous quality improvement. Legal minimums must be satisfied, but the real aim of continuous quality improvement is to ensure that you have put in place systems which will support your providers in their efforts to provide quality, cost-efficient care that goes beyond the minimums and incorporates within the system a mechanism which uses continuous feedback and review to help the provider to continue to improve. Quality care does not happen by accident, but rather by careful planning and work on the part of providers, States, and patients. It is this larger effort that will, in the long run, determine the success or failure of your State's Medicaid Quality Strategy.

Consequently, CMS has reviewed Iowa's "Medicaid Managed Care Quality Assurance System," dated 2007, in regard to the following:

1) Comprehensiveness of Strategy
2) Objectives
3) "Terms and Conditions" for compliance requirements
4) Code of Federal Regulations
5) Specific Comments on the Quality Strategy
6) CMSO Quality Initiative

The two separate documents dealing with physical health and behavioral health were both reviewed.

1) Comprehensiveness of Strategy

CMS would like each state to have a single, comprehensive, integrated Quality Strategy, covering managed care for both physical health and behavioral health. A comprehensive plan covering both physical health and mental health would facilitate achievement of the State's goals and objectives in managed care.

Iowa's Quality Strategy is divided into two documents, one dealing with Behavioral Health and Substance Abuse and one dealing with Physical Health. A single, comprehensive Quality Strategy would strengthen the effectiveness of the State's overall Strategy by addressing the interaction between the two systems.

2) Objectives

Iowa lists the following objectives for the State's Behavioral Quality Strategy:

- Inpatient 30-day readmission by children and adults shall be 15% or less.
- The Contractor shall arrange or participate in 450 JTP conferences per contract period with the consumer participating in at least 97% of the JTP conferences.
- The average time between mental health hospitalizations shall not fall below 60 days for children and adults.
- The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 15% of all children admissions and 10% of all adult admissions.
- At least 6% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.
- 90% of persons discharged from mental health inpatient care will receive other treatment services within 7 days of discharge date.
- 60% of enrollees discharged from ASAM Levels III.5 and III.3 and receiving a follow-up substance abuse service within 14 days of discharge

- 90% of all discharge plans written for enrollees being released from a mental health inpatient hospitalization shall be implemented.

- A discharge plan shall be documented on the day of discharge for 90% of enrollees being discharged from the following mental health settings: inpatient, partial hospitalization, and day treatment. The discharge plan at a minimum includes the following first three items: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) as applicable; restrictions (if any) on activities and when they can return to work/school including the school setting.

- 95% of enrollees who received services in an emergency room and for whom inpatient care was requested but not authorized shall have a follow-up contact within 3 business days of the date the Contractor is notified of the ER service.

- At least 60% of enrollees discharged from 24-hour substance abuse services including PMIC (excluding Level III.1 – Halfway House) receive a follow-up substance abuse service within 30 days of discharge.

- A discharge plan shall be documented on the day of discharge for 90% of enrollees being discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting. The discharge plan at a minimum includes the following first two items: 1) the next appointment(s) and/or place of care, 2) emergency contact numbers, and 3) as applicable; medications, restrictions (if any) on activities and when they can return to work/school including the school setting.

- The percentage of enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 3% of all mental health inpatient discharges of children under the age of 18.

- Medicaid claims shall be paid or denied within the following time periods: 85% within 12 calendar days; 90% within 30 calendar days; 100% within 90 calendar days

- 95% of appeals will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal, other than in instances which the enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.

- In the event of an extension, 95% of the time the Contractor will resolve the appeal within the additional 14 calendar day period, and, in the case of a DHS-approved extension, give the enrollee written notice of the reason for the decision to extend the timeframe.

- 95% of expedited appeals will be resolved as expeditiously as the enrollee's health condition requires and within 3 working days from the date the Contractor received the appeal, other than in instances which the enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.
  In the event of an extension, 95% of the time the Contractor will resolve the appeal within 14 calendar days from the end of the 3 working day period, and, in the case of a DHS-approved extension, give the enrollee written notice of the reason for the decision to extend the timeframe.

- 95% of grievance will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 90 calendar days of the receipt of all required documentation.

- Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 60% within 30 days; 100% within 90 days.

- Revisions to the Provider Manual shall be distributed to all network providers at least 30 days prior to the effective date of the revisions.
  Mailing dates of provider manual material shall be sent at least 30 calendar days prior to the effective date of material contained in the mailing. This measure applies to all information sent for all network providers.

- New enrollee information, including a list of network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name was provided to the Contractor. The standard shall be met for 95% of all enrollees, and in no case shall more than 15 working days elapse.

The Physical Health Quality Strategy does not contain comparable quantified objectives.

Feedback: CMS would like each state to convert the objectives of its Quality Strategy to quantified, measurable performance targets (e.g., as target percentage changes in quantitative measures) as part of its continuous quality improvement program. Iowa, should, when it integrates the two Quality Strategies, develop quantified objectives for its Physical Health plan as it has already done for its Behavioral Health Plan.

3) "Terms and Conditions" concerning compliance with regulation

Feedback: Iowa's "Terms and Conditions" have no provisions which would waive or limit application of the Quality Assessment or EQRO provisions of the managed care regulations. Therefore, this review was performed in consideration of all components of these regulations.

4) Code of Federal Regulations

As noted in Appendix A, the State is required to have a Quality Strategy that addresses all mandatory elements outlined in 42 CFR 438.202 and 42 CFR 438.204. Appendix B describes these regulatory requirements for state quality strategies by area.

Feedback: CMS believes that Iowa's Quality Strategy adequately meets all regulatory requirements for state quality strategies in Appendix B. This is true of both the Physical Health and the Behavioral Health documents.

5) Specific Comments on the Quality Strategy

Appendix C of this review includes a tool developed by CMS that provides a listing of topics that CMS would like to see addressed in a state's Quality Strategy.

Feedback: CMS believes that Iowa's Quality Strategy adequately addresses the following topics (Appendix C):

Overview
MCO / PIHP Requirements
Strategy Effectiveness.
Quality and Appropriateness of Care
MCO / PIHP Contractual Compliance
Evolution of Health Information Technology
Improvement / Intervention

However, CMS believes that Iowa's Quality Strategy does not adequately address the following topics (Appendix C):

Strategy Objectives
Conclusions.

Feedback: As stated above, Iowa has quantified objectives only for its Behavioral Health Plan. It needs to develop quantified objectives for its Physical Health Plan as part of a unified Quality Strategy. As to the Conclusions section, CMS would appreciate more information from Iowa in the Quality Strategy on its participation in pay for performance, health information technology, and other value-based purchasing initiatives. Neither the Physical Health nor the Behavioral Health documents contain much information on these topics.

Some other minor issues require revision. The Behavioral Health Document contains many references to "MCOs," but that carve-out is structured as a PIHP. This confusion could be eliminated by using the phrase MCO/PIHP in any new combined Quality Strategy. Also, both documents contain references to a CMS document entitled, "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States." This document was superseded by the new Managed Care Regulations and references to it in the Quality Strategy should be deleted. One other minor issue is that JCAHO no longer accredits MCOs and consequently the references in the documents to "JCAHO and NCQA" as acceptable accrediting agencies should drop the JCAHO language.

Taken as a whole, the Iowa Quality Strategy is a thoughtful and well-drafted document. The State has clearly set forth its overall quality agenda. The above recommended changes are not of immediate concern and should be considered when the next overall revision is done.

6) CMSO Quality Initiative (Appendix D)

See attachment.

Appendix A

Regulatory Requirements

CFR 438.204 Elements of State Quality Strategies

At a minimum, State strategies must include the following:

(a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.

(b) Procedures that—

(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

(3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.

(d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.

(e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.

(f) An information system that supports initial and ongoing operation and review of the State's quality strategy.

(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

- Continues next page -

Regulatory Requirements: continued

CFR 438.202 State Responsibilities

Each State contracting with an MCO or PIHP must do the following:

(a) Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

(c) Ensure that MCOs, PIHPs, and PAHPs comply with standards established by the State, consistent with this subpart.

(d) Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed.

(e) Submit to CMS the following:

(1) A copy of the initial strategy and a copy of the revised strategy, whenever significant changes are made.

(2) Regular reports on the implementation and effectiveness of the strategy.

Appendix B

CMS Review List for
State Quality Assessment & Improvement Strategies

Each state must submit to CMS:

- a copy of the initial strategy;

- a copy of the revised strategy whenever significant changes are made; and

- regular reports on the implementation and effectiveness of the strategy.

The quality strategy must include:

I. Process for quality strategy development, review, and revision

A. A description of the process the state will use for the development of the quality strategy.
B. A description of the formal process the state will use to obtain beneficiary and stakeholder input and public comment before final adoption in final.
C. A description of how and how often the State will conduct periodic reviews of the effectiveness of the strategy.
D. The state's definition of "significant changes" to strategy that will trigger shareholder input.
E. The state's timeframes for updating the quality strategy.

II. Managed care program goals and objectives

A description of the goals and objectives of the state's managed care program, including priorities, strategic partnerships, etc.

III. Medicaid contract provisions

Either:

1) the provisions in the State's Medicaid MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement, or

2) a summary description of the contract provisions in its Medicaid MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement. If the State chooses the latter

option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.

IV. State standards for access to care

A. A summary description of the state standards for access to care with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.206-438.210 including—

1. Availability of Services
   a) Maintains and monitors a network of appropriate providers.
   b) Provides female enrollees with direct access to a women's health specialist.
   c) Provides for a second opinion from a qualified health care professional.
   d) Must provide necessary services that are not available in the network.
   e) Requires out of network providers to coordinate with the MCO or PIHP with respect to payment.
   f) Demonstrates that providers are credentialed.
   g) Timely access.
   h) Cultural considerations.

2. Assurances of adequate capacity and services
   a) Offers an appropriate range of preventative, primary care, and specialty services.
   b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution.

3. Coordination and continuity of care
   a) Ensure that each enrollee has an ongoing source of primary care,
   b) Coordinate all services that the enrollee receives,
   c) Share identification and assessment information to prevent duplication of services for individuals with special health care needs.
   d) Protect the enrollees privacy in the process of coordinating care
   e) Additional services for persons with special health care needs, including:
      i. Identification;
      ii. Assessment;
      iii. Treatment plans; and
      iv. Direct assess to specialists.

4. Coverage and authorization of services
   a) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, and PAHP is required to offer.
   b) Specify what constitutes "medically necessary services".
   c) That the MCO, PIHP, or PAHP have in place and follow written policies and procedures for authorization of services.
   d) That any decision to deny a service be made by an appropriate health care professional.

B. Detailed information related to the access to care standards, including—

Identification of mechanisms the State uses to identify persons with special health care needs to MCOs, PIHPs, and PAHPs.

Identification of standards the State uses to determine the extent to which treatment plans are required to be produced by MCOs, PIHPs, and PAHPs for individuals with special health care needs.

V. State standards for structure and operations

A. A summary description of the state standards for structure and operations with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.214-438.230 including—

1. Provider selection
    a) Each State must establish a uniform credentialing and recredentialing policy
2. Enrollee information
3. Confidentiality
4. Enrollment and disenrollment
5. Grievance system
6. Subcontractual relationship and delegation
    a) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor

B. Detailed information related to the structure and operation standards, including—

1. State procedures for the review of the records of MCO and PIHP grievances and appeals, and for identifying and resolving systemic problems.

VI. State standards for quality measurement and improvement

A. A summary description of the state standards for quality measurement and improvement with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.236-438.242 including—

1. Practice guidelines
    a) Based on valid and reliable clinical evidence.
    b) Consider the needs of MCO's, PIHP's, and PAHP's enrollees.
    c) Adopted in consultation with contracting health care professionals.
    d) Reviewed and updated as appropriate.

2. Quality assessment and performance improvement program
    a) Conduct performance improvement projects.
    b) Submit performance measurement data.

c) Have in effect mechanisms to detect both overutilization and underutilization of services.
d) Have in effect mechanisms to assess quality and appropriateness of care to enrollees.
e) Measure performance and/or report performance data to the State.
f) Report the status and results of each project to the State as requested.
g) State must review at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program.

3. Health Information Systems
a) Collect data on enrollee and provider characteristics as specified by the State.
b) Ensure the data received from providers is accurate and complete.
c) Make all collected data available to the State and upon request to CMS.

B. Detailed information related to the quality measurement and improvement standards, including—

1. A description of the methods and timeframes to assess the quality and appropriateness of care and services to all Medicaid beneficiaries.

2. An identification of the populations the State will consider when determining individuals with special health care needs.

3. The state standards for the identification and assessment of individuals with special health care needs.

4. Procedures the state will use to separately assess the quality and appropriateness of care and services furnished under the State's MCO and PIHP contracts to all Medicaid enrollees and to individuals with special health care needs.

5. A description of the state's information system(s) and how these systems support the initial and ongoing operation and review of the State's quality strategy; for example, a description of how the state intends to use its MMIS and any other system to monitor quality, produce reports on performance indicators, collect data on different quality measures, etc..

VII. State monitoring and evaluation

A description of how the state will regularly monitor and evaluate MCO and PIHP compliance with the State-established standards for access to care, structure and operations, and quality measurement and improvement; this may include for example, a description of the types of reviews the state will perform, how often it will monitor these standards, and how the results of the State's efforts will be reported.

A. Arrangements for external quality reviews

A description of the state's arrangements for an annual, independent external quality review of the timeliness, outcomes, and accessibility of the services covered under each MCO and PIHP contract. This section should include a broad description of the scope of the contract (e.g., calculating HEDIS measures or designing performance improvement projects), including the term of the contract.

B. Nonduplication of mandatory external quality review activity

A description of the standards and activities that will be monitored through the use of Medicare or private accreditation review information and an explanation of the rationale for why the State review would be duplicative of review activity already performed.

VIII. Procedures for race, ethnicity, and primary language

A. A description of how the state identifies the race, ethnicity, and primary spoken language of each Medicaid MCO and PIHP enrollee and how it will provide this information on each Medicaid enrollee to the MCO and/ or PIHP at the time of enrollment.

B. A description of the state's efforts to collect information on ethnicity and primary language spoken for any beneficiaries receiving Supplemental Security Income, as this information is not available from the Social Security Administration.

C. An identification of the State's race, ethnicity, and primary language categories, including a description of how it defines and categorizes "ethnicity".

IX. National performance measures and levels

For MCOs and PIHPs, the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders. (Note: at this time no performance measures and levels have been developed. At the point CMS undertakes their development, the States will be consulted in each phase of the development process, including the specification of the level of information to be included in the State's quality strategy.)

X. Intermediate sanctions

For MCOs only, a description of how the state uses intermediate sanctions in support of its quality strategy. These sanctions must, at a minimum, meet the requirements specified in 42 CFR 438 Subpart I. The State's description should specify its methodology for using sanctions as a vehicle for addressing identified quality of care problems.

Appendix C

Table B of the "State Quality Strategy Toolkit for State Medicaid Agencies, October 2006"

COMPONENTS TO ADDRESS IN A QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

Quality Strategy Elements and Key Questions	Correlates to Structure Section	Potential Sources Of Information	Additional Information
Overview	I.A	• BBA • MCO / PIHP contracting and turnover experience • Population description / changes • Driver for implementation of Managed Care	• Include history of managed care program • Process to get public input on strategy • How often will strategy be evaluated and revised?
Strategy Objectives	I.B	• Results from Prior program experience • Results from Performance Measurement / EQRO or other Quality Related Reporting	• Include measurable target (e.g. % increase or decrease) • May directly reference an intervention / initiative driving the objective
Quality and Appropriateness of Care How are the race, ethnicity, and primary language spoken of each enrollee identified and transmitted to MCOs? How is EQRO Technical Report used to evaluate quality and appropriateness of care? Does the State require specific performance measures or performance improvement projects based on Strategy Objectives, and if so – what are the performance standards?	II.A	• MMIS data • EQR Technical Report and recommendations • MCO required data reporting • Report Card efforts • Pay for Performance • Value Based Purchasing	• Include state standards for quality measurement and improvement • Include any standards that will be reviewed using private or Medicare accrediting information

Are any clinical guidelines provided to managed care plans?			

Quality Strategy Elements and Key Questions	Correlates to Structure Section	Potential Sources Of Information	Additional Information
MCO / PIHP Requirements What requirements has the State established for its MCOs / PIHPs / HIOs in the following domains: • Access to Care • Structure and Operations • Quality measurement and improvement	II.B.	• Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQR activities • Special studies • Contract compliance review • Provider network reporting	• Include availability of services, coordination and continuity of care and any utilization review requirements managed care plans must meet • Include required enrollee information, disenrollment; grievance / appeals, and confidentiality requirements that managed care plans must meet • Include encounter data requirements • Include specific performance measures and / or performance improvement projects • Include practice guidelines if required
MCO / PIHP Contractual Compliance What contract provisions hold the MCO / PIHP / HIO accountable for meeting the standards outlined in preceding sections? What monitoring mechanisms does the State have in place to provide oversight to MCO / PIHP / HIO?	II.B	• MCO / PIHP Contract • State-specific Statutes if applicable • MCO / PIHP Performance incentive program • Provider incentive program • NCQA information • Complaint, grievance and appeals reporting • EQR studies • Special studies • CFR Part 438 – Subpart D	• Include incentives and disincentives (sanctions) offered to MCOs as tool for quality • Include data reporting / analysis activities
Evolution of Health Information Technology	II.C	• MMIS Review	• Include any health information technology

Is there an information system that supports initial and ongoing operation and review of the State's quality strategy objectives and progress toward performance targets?		• Encounter Data System • NCQA information • Regional or multi-state IT collaborative • New IT contracts • Implementation / revision of registries • Needs assessments for implementation of electronic health records • Telemedicine initiatives • Provider / MCO-PIHP Profiling • EQR Technical report recommendations • CMS Quality Roadmap	initiatives that will support the objectives of the strategy.

Quality Strategy Elements and Key Questions	Correlates to Structure Section	Potential Sources Of Information	Additional Information
Improvement / Interventions How will the State implement interventions specific to each Strategic Objective? What interventions are under consideration pending baseline reporting of targeted information? What interventions are under development?	III	• Cross-State Agency Collaborative • Performance Improvement Project activities • Pay-for-Performance Incentives • Value-Based Purchasing incentives and or disincentives • Telemedicine • Health Information Technology Changes	
Strategy Effectiveness What are the planned evaluations (frequency, estimated target dates)? What are the reporting requirements for MCOs / PIHPS to State and from State to CMS?	IV		• Consider aligning routine reporting mechanisms from MCOs / PIHPs / EQR with planned evaluation periods
Conclusions	V	• Performance	

What particular successes could be considered best practices? What ongoing challenges does the State face in improving the quality of care for Medicaid beneficiaries? What recommendations does the State make for ongoing Medicaid quality improvement activities in the State?		Improvement Project activities • Pay-for-Performance Incentives • Value-Based Purchasing incentives and or disincentives • Telemedicine • Health Information Technology Changes	

Appendix D

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

Value-Based…Results-Driven…Healthcare:

The Medicaid / SCHIP Quality Initiative

August 2006

The Center for Medicaid and State Operations (CMSO) is committed to supporting State Medicaid and State Children's Health Insurance Programs (SCHIP) in their efforts to achieve safe, effective, efficient, patient-centered, timely, and equitable care. The CMSO will work in partnership to achieve these goals, recommended by the Institute of Medicine, by engaging states, providers, consumers, and others in implementing evidence-based care, rewarding quality performance, controlling costs, and promoting the use of information technology. The vision, as noted in the *CMS Quality Improvement Roadmap*, is the right care for every person every time.

States administering Medicaid and SCHIP are challenged to provide quality services to an expanding population within budget constraints. Increasingly, federal and state governments, health care professionals, and insurers are exploring reforms in the current payment systems which typically focus reimbursement on the number of services and procedures provided, rather than the quality and value delivered. Demand continues to grow for Federal leadership in these critical and complex areas of health care reform.

As one of the largest payers of healthcare in the United States, CMS has an important role to play in supporting states in their efforts to implement quality improvement strategies including pay-for-performance (P4P) programs, care coordination, patient safety initiatives, e-prescribing, electronic medical records, public reporting, evidence-based guidelines and performance measurement. States are eager to explore these innovative programs and have in fact led the way in many instances.

For example:

Indiana recently submitted an amendment to its State Plan to enhance the delivery of child health through the *Indiana Health Information Exchange*, a collaboration of Indiana health care institutions. The collaborative was formed for the purpose of using information technology and shared clinical information to improve the quality, safety, and efficiency of health care to children in Medicaid and SCHIP.

California, Michigan, and New York have implemented *Performance Based Auto-Assignment Programs* that rewards health plans with superior performance. The programs create an incentive to improve Medicaid quality and preserve the safety net by increasing enrollee volume and payment to those plans that provide a consistent level of quality improvement.

Louisiana is currently planning to expand a *Disease Management Outcomes Measurement System* that utilizes nationally recognized performance measures to improve outcomes in diabetes, asthma, and cancer screening. The expansion will promote improvement in the delivery system design, clinical information systems, patient self-management, and electronic decision support tools for practitioners.

Arizona recently developed a position paper that clearly articulates a need for the federal government to provide incentives to state Medicaid programs to develop methods of reducing medical error and improving quality measurement by exploring the development of models for P4P programs and electronic health networks.

CMSO will utilize a number of available avenues to assist states in their efforts to improve quality of care and reduce cost. The newly created Division of Quality, Evaluation, and Health Outcomes will provide technical assistance to states as they seek to advance quality improvement activities. CMSO also will strengthen the quality focus in its guidance for waiver applications, state quality strategies, external quality review activities, and state plan amendments.

Quality Strategy

CMSO is an integral part of CMS and as such, participated in the development of the agency-wide *CMS Quality Improvement Roadmap.* The five strategic components of the plan served as the foundation for the CMSO quality strategy. The CMSO quality strategy was modified to acknowledge the unique relationship between the federal government and states. Consistent with the philosophy of continuous improvement, CMSO attempts to avoid punitive and costly mandates but instead strives to encourage states participation in activities proven to improve the lives of beneficiaries.

CMSO recognizes the purchasing power held by federal and state governments and will join the national efforts to promote innovative approaches to transforming the delivery of health care. This transformation strategy requires CMSO to serve as a convener, change agent, and knowledge transfer organization. The basic elements of the plan include:

- Evidenced-Based Care and Quality Measurement
- Pay-for-Performance
- Health Information Technology
- Partnerships
- Information Dissemination and Technical Assistance
- Health Care Disparities

Evidenced-Based Care and Quality Measurement

CMSO will work with states to improve performance measurement and ultimately the quality of care. The need for consistency in performance measurement is becoming more evident as the demand for data continues to increase. Payers and providers are finding it

nearly impossible to fulfill the multiple requests for data, all of which have different data requirements unique to the individual payer. Federal and state governments, accreditation bodies, insurers, and health care professionals have now joined together to come to consensus on common evidence-based measure sets that have wide acceptability in the healthcare industry.
A voluntary consensus approach to measures development ensures that states will be able to maintain flexibility in measure selection while benefiting from having a menu of nationally recognized validated and tested measures from which to choose. Additionally, by using common measures, states can minimize the need to overhaul their information technology systems because they may be able to take advantage of existing databases such as those available through QualityNet Exchange, a secured communications site for data exchange.

Many states have already adopted the use of nationally recognized performance measures and utilize them in a number of areas including incentive programs, public reporting of quality, and in the development of policy reports. Maryland, Massachusetts, Minnesota, Ohio, Iowa, and Wisconsin are a few of the states that collect standardized measures. All of these states conduct internal quality improvement activities and report quality results publicly on their Web sites.

Many other opportunities are available for states to conduct data mining of existing systems. CMSO will help states explore opportunities to develop genetic-algorithm-driven data mining programs for such system as the MMIS databases or the MSIS database. Multiple opportunities may also exist to help states develop initiatives to influence pharmacy benefits through data mining of pharmaceutical databases. The data will be useful when making decisions on formularies, adoption of formularies from private health plans, and development of joint formularies.

National databases such as those used to generate the National Nursing Home Compare data also provide states with a readily available source of information upon which to make decisions related to quality of care. Additionally, CMS has built improved infrastructure for the survey and certification system, such as a new complaint tracking and management information system, to identify and track needed improvement in quality. Significant investments also have been made in reporting and tracking such quality measures as the prevalence of pressure ulcers, incontinence, and physical restraints.

CMSO can play an important role in promoting measures of quality for which there is broad clinical acceptance. For example, CMSO, working with the Office of Clinical Standards and Quality (OCSQ), will advance a project to improve quality of care for neonates. By sharing information about successful health outcomes and cost savings, other states will be encouraged to undertake similar programs customized to their unique needs and resources.

Examples of measurable project goals include:

- Increasing the use of antenatal corticosteroids in pregnant women who are at risk for preterm delivery (reduces the risk of death, respiratory distress syndrome, and intraventricular hemorrhage); and

- Increasing the use of prophylactic surfactant administration in eligible neonates (reduces the risk of pneumothorax, pulmonary emphysema, and mortality).

The above guidelines are well accepted and the potential for improved quality and cost reduction is great. The March of Dimes estimates that $13.6 billion is spent on care for premature infants with nearly half of this cost or $6.8 billion paid by Medicaid programs. NIH estimates savings of $3000.00 per neonate treated with corticosteroids alone. Further, NIH notes that only 15% or eligible neonates receive the recommended therapy. If the percentage were increased to 60%, a conservative estimate of the annual savings in health care cost would be $157 million from the initial hospitalization alone.

Based on prevalence, health care expenditure, and ability to make a positive impact through evidence-based approaches, CMSO, in partnership with states, will develop additional quality improvement program options.

Pay-for-Performance / Quality (P4P)

P4P is a quality improvement and reimbursement methodology aimed at changing the current payment structure which primarily reimburses based on the number of services provided regardless of outcome. P4P attempts to introduce market forces and competition to promote payment for quality, access, efficiency, and successful outcomes.

P4P is in its early stages of development and a great deal of work still must be done to determine the best method of approaching a comprehensive program. Several different models exist for P4P including extensive disease management programs. One demonstration currently in progress includes the *Disease Management Demonstration for Chronically Ill Dual Eligible Beneficiaries*. Under this demonstration, disease management services are being provided to dually eligible beneficiaries in Florida. LifeMasters, the demonstration organization, is being paid a fixed monthly amount per beneficiary and is at risk for 100% of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and LifeMasters.

CMSO will provide technical assistance to those states that voluntarily elect to implement P4P programs. Additionally, CMSO will convene states for a conference designed to explore methods of propelling P4P programs. Efforts will be geared toward promoting the following important concepts in P4P:

Overarching Principles: P4P programs must be:

- Data driven
- Beneficiary-centered
- Transparent
- Developed through partnerships
- Administratively flexible

Quality Components: P4P programs should be built on:

- Evidence-based guidelines

- Consistent measures of access, quality, costs, and satisfaction
- Coordinated care programs
- Health information technology

Incentive Structure: P4P incentives must be:

- Equitable and fair to program participants including the beneficiary
- Timely
- Sufficient to motivate improvement
- Flexible enough to provide payment for innovative care processes
- Structured to avoid unintended consequences

Health Information Technology (HIT)

HHS currently has a 10-year plan to transform the delivery of health care by building a new health information infrastructure, including electronic health records and a new network to link health records nationwide. The plan lays out the broad steps needed to achieve always-current, always-available electronic health records (EHR) for all Americans. National HIT activities are currently coordinated through the Office of the National Coordinator for Health Information Technology (ONCHIT). EHR systems will enable physicians and other health professionals to electronically tap into a wealth of treatment information as they care for patients and improve quality and patient safety.

Many states have embraced advancements in HIT. For example New York recently announced its Federal-State Health Reform Partnership (F-SHRP) with a plan to reinvest $1.5 billion of federal fund savings that were achieved under New York's section 1115 waiver. One component of the plan includes investing in health IT, including e-prescribing, electronic medical records, and regional health information organizations.

CMSO will join the CMS Quality Council Health Information Technology Workgroup in developing plans that will serve as models for states. The newly created Division of Quality, Evaluations and Health Outcomes has been charged with compiling information for states and providing technical assistance as they move forward with HIT activities.

Partnerships

Partnerships are essential to accomplishing the work ahead. The collective efforts of partners interested in true reform will have a great yield. Following are only a few examples of required partnerships:

- **National Association of State Medicaid Directors (NASMD)** – CMSO is working with NASMD to further refine a quality strategy and determine areas of collaboration. Formal communications channels for quality activities will also be established to facilitate the dissemination of information.

- **Agency for Healthcare Research and Quality (AHRQ)** – The Medicaid / SCHIP Quality Workgroup is currently collaborating with AHRQ on the next publication of the *National Healthcare Quality Report*. This report has been in existence for two years and, for the first time, CMSO will explore the publication of a section specific to Medicaid quality. Additionally, the workgroup is collaborating with AHRQ on a *Care Management Knowledge Transfer Project*.

- **Center for Health Care Strategies (CHCS)** – CMSO will work with CHCS in their efforts to provide training and technical assistance to help states, health plans, and consumer organizations effectively use managed care to improve the quality of services for beneficiaries, reduce racial and ethnic health disparities, and increase community options for people with disabilities.

- **National Quality Forum (NQF)** – The National Quality Forum currently has an informal workgroup established to explore pediatric quality of care measures. CMSO will begin a dialogue with NQF on potential measures of interest to Medicaid.

- **American Health Quality Association (AHQA)** – AHQA, the trade association for Quality Improvement Organizations (QIOs), has expressed an interest in working with states, CMSO and OCSQ to convert the current QIO / QIO-like review of quality and access in Medicaid fee-for-service and managed care into more meaningful quality improvement work for mothers, children, and the dually enrolled population.

- **National Committee on Quality Assurance (NCQA)** – NCQA continually addresses strategies and specifications for performance measures. Many of the measures that will be discussed over the next several months include attention deficit hyperactivity disorder (ADHD), diabetes, dental care, and asthma.

- **American Academy of Pediatrics (AAP)** – AAP has expressed strong support for improving the quality of care in the Medicaid / SCHIP population by exploring valid measures of quality and appropriate incentives for quality care. CMSO will continue to foster a collaborative relationship with AAP.

- **National Association of Children's Hospitals and Related Institutions (NACHRI)** – NACHRI has begun a dialogue with the CMSO to encourage improved pediatric performance measurement, national demonstrations, value based purchasing and other areas of importance in quality. CMSO will work with NACHRI to further develop these ideas.

- **Internal Partners** – The Medicaid / SCHIP Quality Workgroup and its subgroups will provide a formal structure for advancing quality efforts related to these programs. CMS regional offices will play a special role in information collection, analysis, information dissemination, and technical assistance. CMSO has also begun dialogue with internal CMS partners on such projects as HCAHPS (hospital experience of care), the Surgical Complication Interventions Project (SCIP), the Ambulatory Care project, and others.

Information Dissemination and Technical Assistance

Information dissemination, knowledge transfer, and technical assistance is extremely important in the Medicaid and SCHIP programs given that states enjoy wide flexibility in program implementation. CMSO will facilitate the sharing of model practices, lessons learned and innovative approaches to emerging issues through issues briefs, analysis of demonstration evaluations, development of a quality Web site, participating in conferences and Web casts and other methods. The Medicaid / SCHIP Quality Workgroup will develop and implement a formal communications strategy to ensure successful dissemination of information.

Health Care Disparities

As part of the Centers for Medicare & Medicaid Services' (CMS) overarching initiative to support health care quality improvement to underserved Medicare and Medicaid beneficiaries, the Center for Medicaid and State Operations (CMSO) has engaged in an intra-agency, private, and public sector collaboration with States, various community-based organizations, stakeholders, and underserved communities interested in addressing health disparities, incorporating a health disparities component into the Agency's quality initiatives, and providing beneficiaries with information about CMS' programs.

According to the *National Healthcare Disparities Report*, developed by the Agency for Healthcare Research and Quality (AHRQ), though there are differences in care seeking behavior, which are attributable to factors that include cultural beliefs, linguistics, and lifestyle choices, health disparities often represent an 'inequality in quality' and usually lacks the necessary framework for quality as defined by the Institute of Medicine (IOM): patient safety, patient-centeredness, timeliness, efficiency and equity.

As part of CMS's broader disparity strategy, the CMSO charge to address racial and ethnic health disparities in Medicaid and SCHIP will focus on the following objectives:

1. Disseminate information about promising / best practices in health disparities in Medicaid and SCHIP to the forum and external organizations.

2. Identify vulnerabilities and areas of opportunity in Medicaid and SCHIP for quality improvement and the reduction of health disparities in Medicaid beneficiaries.

3. Identify and collaborate with States and external organizations / resources to develop partnerships to reduce health disparities in Medicaid and SCHIP.

Moving Forward with All Deliberate Speed

The Medicaid and SCHIP programs are experiencing an unprecedented number of demonstration requests and state plan amendments that are focused on value based, results-driven approaches to providing health care to an expanded number of citizens. Professional organizations, providers, and consumers have growing expectations for Federal leadership in ensuring quality services within the limitation of resources. No one approach will satisfy the needs of all. CMSO looks forward to participating in the debate, driving improvement, and ultimately ensuring a system that works for America's most vulnerable populations.

Tab E

Iowa External Quality Review Organization (EQRO)
2005 Annual Technical Report (ATR)

Assessment of Iowa's 2006 - 2007 External Quality Review Annual Technical Report (08/20/2008)

Thank you for your submission of the 2006 - 2007 External Quality Review Annual Technical Report for the managed care organization (MCO) participating in Iowa's managed care program and the Prepaid Inpatient Health Plan (PIHP). The Centers for Medicare & Medicaid Services (CMS) has reviewed these reports in an effort to support States in activities designed to improve quality and access to care that is safe, effective, efficient, timely, person-centered, and equitable. This assessment is based upon the criteria stated in the EQRO Technical Report Review Tool for CMS Regional Offices.

The External Quality Review must include the following deliverables:

1. A detailed technical report describing the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care;
2. an assessment of each plan's strengths and weaknesses with respect to quality, timeliness, and access to care;
3. as the State determines, methodologically appropriate, comparative information about all plans;
4. recommendations for improving the quality of health care services furnished by the plans, and
5. an assessment of the degree to which each plan has addressed effectively the quality improvement recommendations made by an EQRO during the prior year's review.

The EQRO has submitted these deliverables in separate reports for the MCO (Coventry) and the PIHP (Magellan) providing managed care services to Medicaid beneficiaries in the State.

Background

Medicaid Managed Care was introduced to Iowa in 1986 when the State contracted for the delivery of medical/surgical services in Scott County on a risk-based, capitated basis. The State contracted with John Deere Health Plan as the first Medicaid MCO. In 1990 the State received approval of a 1915(b) Freedom of Choice waiver from CMS. The waiver allowed the State to implement the Medicaid Patient Access to Service Systems or MediPASS program in seven counties. Today, out of the 99 counties in the State of Iowa, the MediPASS program is offered in 95 counties, with two counties offering an MCO option. There are approximately 138,000 members in the PCCM (MediPASS) program and 4,800 in the MCO program. This enrollment represents approximately 43% of the total Medicaid population.

In counties with Medicaid managed care, the program is mandatory for recipients receiving assistance through the Family Investment Program (FIP) and FIP-related programs (TANF). Medicaid enrollees may choose between the managed care options available in their county, MCOs or PCCM. If the beneficiary fails to make a choice, they are assigned to a plan and provider.

Iowa currently contracts on a capitation basis with one MCO, Coventry Health Care of Iowa, Inc. Coventry Health Care of Iowa is a risk-based entity which accepts a capitation rate set by the State. The MediPASS program is a primary care case management program that enrolls the

recipient with a primary care physician (PCP) or patient manager who is responsible for providing primary care and for coordinating or authorizing other necessary care. Participating physicians are paid a monthly fee for providing case management services to assigned beneficiaries. All other services provided through the MediPASS program are reimbursed on a fee-for-service basis.

The Iowa Plan

In 1995 the State began separate managed mental health and substance abuse programs which served most beneficiaries not enrolled with an HMO who were under age 65. In July of 1997, mental health and substance abuse services were carved out of the MCO responsibility and moved to the mental health and substance abuse PIHP, which is a statewide contract, called the Iowa Plan. This program operates under a 1915(b) waiver granted by CMS.

The Iowa Plan for Behavioral Health (the Iowa Plan) integrates mental health care and substance abuse treatment and builds on the two previous separate managed care programs. The Iowa Plan is administered under a contract between IME and Magellan Health Services. Most Medicaid eligible members under the age of 65 are enrolled in the Iowa Plan. Current enrollment is approximately 285,000.

Through the use of savings in its waiver, Iowa is able to provide more services to Medicaid beneficiaries through the Iowa Plan than under traditional Medicaid fee-for-service. These "additional" services are provided under Section 1915(b)(3) authority and allow for the use of a number of community-based strategies that offer a cost-efficient, less restrictive, and more effective alternative to hospitalization.

In accordance with the Centers for Medicare and Medicaid Services (CMS) rule, section 438.350, the EQRO, Iowa Foundation for Medical Care (IFMC), conducts onsite evaluations of Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) under contract with the Iowa Department of Human Services (DHS). The purpose of the evaluation is to assure that each contracted MCO/PIHP is providing quality services for its Medicaid members in accordance with the CMS Protocols. Plan compliance with these new protocols was effective August 2003 with much more stringent requirements per Federal regulations at 42 Code of Federal Regulations, section 438.350

Expectations

For the review of each MCO/PIHP, the State or its agent is required to conduct the following mandatory EQR activities:

- Validation of performance improvement projects required by the State
- Validation of reported MCO performance measures
- Assess standards for access to care, structure and operations, and quality measurement and improvement

Federal regulations at 42 CFR 438.364 requires that each ATR include objectives, data collection and analysis methods, description of data obtained, conclusions drawn from the data, an

assessment of each MCO's strengths and weaknesses, recommendations for quality improvement, and (as appropriate) comparative information about the various health plans.

The CMS also seeks confirmation through the Annual Technical Reports that each MCO addresses disparities in health care outcomes and uses health information technology to implement the State's quality strategy, as cited at 42 CFR 438.204(b)(2) and (f) respectively.

Validation of Performance Improvement Projects (PIP)

Federal regulations at 42 CFR 438.240(d) require MCOs to have an ongoing program of PIPs that focus on clinical and non-clinical areas. Regulations at 42 CFR 428.240(e) indicate that the annual EQR must assess the impact and effectiveness of the MCO performance improvement program. The EQRO reviewed three PIPs proposed by the MCO for 2006 implementation in various clinical areas that include:

Childhood immunizations
Cervical cancer screenings
EPSDT

The PIHP, as a part of the EQRO on-site evaluation, under the direction of the Iowa DHS, has compiled six Performance Improvement Projects. They are:

Intensive Care Management Program
Outcomes Project
Cultural Differences in Utilization
Co-Occurring Disorders Services
Reward for Quality
Self-Directed Care

The IFMC sought to determine if the proposed PIP would result in sustained and meaningful improvement in outcomes of care. The MCO demonstrated significant improvement in their Performance Improvement Project processes, particularly their data collection and validation processes. There continue to be several areas requiring additional focus leading the IFMC to rate this PIP as Developing.

Some of the strengths of this PIP include documentation of the positive impact of preventive health screening, an effective group process strategy in analyzing results, and response to addressing data collection and validation issues. Processes were very clearly defined and easily validated.

Some of the recommendations include:

- Continued attention is recommended to ensure this level of accurate detail continues.
- Continue to focus attention on detailed descriptive documentation in all sections of the PIP report to ensure the greatest level of understanding and compliance.
- The MCO incorporate a member health outcomes perspective on all studies as opposed to a regulatory perspective on all Performance Improvement Projects.
- The MCO should review all study findings and develop a singular report format so that required information is consistently incorporated. This will address the inconsistencies that continue to be found in the documentation of required studies.

- MCO is encouraged to utilize IDHS and the EQRO team for technical assistance as necessary.

The PIHP population targeted for improvement in outcomes in this study is Plan members with high levels of symptom severity and service utilization. The IFMC found the PIHP Plan continues to demonstrate marginal performance in measuring PIP's. IFMC states "...EQR reports have provided direction to guide improvement efforts but deficiencies and inconsistencies continue in relatively random order. Where previous studies were firmly rated as "developing," this year's review revealed more inconsistencies and inconsistencies of greater magnitude requiring that three studies or half of the plan's efforts be rated as "not valid." This is a disappointing finding which reveals that PIPs have very definitely become a significant weakness for MHS. The IFMC rated the PIP as "developing" again this year.

Some of the recommendations include:

- Continue to request and receive technical assistance from the EQR.
- Work to improve the caliber of documentation of the PIP's incorporating all components of the study definitions
- Utilize a documented data analysis plan
- Develop intervention strategies
- Maintain a clear study design that differentiates between PIP's and PM's
- Train new staff to adequately report on PIP's to achieve and maintain a high level of data analysis

We look forward to seeing future reports that show an improvement in documentation and data analysis.

Validation of Reported MCO Performance Measures

Federal regulations at 42 CFR 438.240(c) provide that the annual EQR must address the MCOs' performance for the standard measures on which they are required to report. The State calculates its own performance measures using MCO-submitted encounter data. The MCO reports on two measures: Lead Screening and Monitoring of PCP Change Due to Dissatisfaction. The PIHP reports on the following two measures: Inpatient Facility Safety Survey and Schizophrenia Readmission.

The reports for both plans specify all performance measures specified by the State. However, the report does not document the State specifications for MCOS/PIHPS for collecting data, calculating rates, or reporting to the State. We would appreciate the state sharing with CMS the documented specifications for MCOS/PIHPS for collecting data, calculating rates, or reporting to the State.

The IFMC recommends that the MCO/PIHP apply the principles of Quality Improvement to the PM process to clearly define areas needing the greatest attention and the interventions that will most effectively address the identified needs. Until such time as improvement strategies are initiated, Performance Measures will continue to be a significant weakness for these Plans.

Assessment of Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement

The two health plans assessed in this review, Coventry (MCO) and Magellan (PIHP) are both NCQA accredited. The EQRO has audited the portions of the operational review which are not deemed by virtue of the NCQA Accreditation.

Information Systems - The report does not document efforts for MCOs/PIHPs efforts to enhance system technology, use of electronic health records, or e-technology. We would appreciate the State sharing with CMS any efforts to enhance system technology, use of electronic health records, or e-technology or the absence of these technologies.

The State does not mention utilizing any form of health information technology organizations. We would appreciate information being shared with CMS on the status of utilization of health information technology organizations.

Health Disparities - CMS was also assessing for attention to disparities in health care but no documentation was noted within the MCO although the PIHP has an intervention on cultural competency training for staff, not plan members. We would appreciate the State providing an update on efforts to assure that individuals for whom English is not the primary language have adequate access to care and necessary translation services.

We encourage Iowa to submit descriptions of any innovative initiatives undertaken through your Medicaid managed care plans that advance quality for Medicaid beneficiaries using the guidelines and format found on the CMS Medicaid/SCHIP Quality website (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNominationProcess.asp#TopOfPage).. See examples of promising practices for other States already posted to this site (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage).

Tab F

Medicaid Information Technology Architecture (MITA): An Opportunity to Improve Medicaid Quality

Medicaid Information Technology Architecture (MITA):
An Opportunity to Improve Medicaid Quality

Abstract

The Medicaid Information Technology Architecture (MITA) initiative seeks to re-orient Medicaid information systems toward a more beneficiary-centered approach that can help achieve the quality goals of the Department of Health and Human Services, the Centers for Medicare & Medicaid Services (CMS), and individual States. The focus of traditional Medicaid Management Information Systems (MMIS) has been on assuring accurate claim adjudication and standardized Federal reporting. The MITA framework seeks to move the MMIS toward a greater focus on the beneficiary, integration of clinical and administrative data, support of program analysis and decision making, and an enhanced capacity for Medicaid to communicate with other programs and payers.

The higher levels of maturity described within the MITA initiative describe scenarios that can support quality improvement by providing a more comprehensive base of information on individual beneficiaries and real-time data on changes in the delivery of services in real time. This can enhance the ability of providers to reduce unnecessary testing and procedures, avoid medical errors and adverse drug events, and assure that appropriate care is delivered. When the higher levels of maturity described in MITA have been achieved, Medicaid program managers will have the ability to identify and target at-risk populations, expedite prior authorization decisions, develop quality statistics for specific providers, and benchmark provider performance to measures calculated by other payers or States.

A July 2007 report issued by the DHHS Office of Inspector General cited numerous examples of State Medicaid HIT and HIE initiatives intended to serve these aims. CMS intends to take a series of concrete actions to explore opportunities for using MITA principles to advance quality goals for Medicaid beneficiaries

Introduction

The purpose of this paper is to provide background on the goals of CMS Medicaid quality efforts and on Medicaid information systems, particularly recent efforts to reorient these systems toward a beneficiary-centered focus guided by Medicaid Information Technology Architecture principles. The paper also considers how the MITA initiative can support quality improvement.

CMS Quality Goals

The quality vision of the Centers for Medicare & Medicaid Services is to provide the right care for every person every time. It seeks to assure that this care is safe, effective, efficient, person-centered, timely; and equitable. [1] The Center for Medicaid and State Operations (CMSO) works to realize this vision for Medicaid and the State Children's Health Insurance Program (SCHIP) through activities in six core areas:

[1] CMS website, Quality of Care Center (http://www.cms.hhs.gov/center/quality.asp)

- *Evidenced-Based Care and Quality Measurement* - CMS supports States in their efforts to improve performance measurement and ultimately the quality of care through the use of evidence-based measure sets that have wide acceptability in the health care industry.
- *Value-Based Payment Methodologies* - CMS supports States in their efforts to implement programs that promote reimbursement for quality, access efficiency, and successful outcomes.
- *Health Information Technology (HIT)* - CMSO encourages States to explore creative uses of HIT that contribute toward the building of new regional and national health information infrastructures.
- *Partnerships* – CMS works with other committed partners to help blend different perspectives and resources in the collective pursuit of common quality goals.
- *Information Dissemination and Technical Assistance* - CMS facilitates the sharing of promising practices, lessons learned, and innovative approaches to emerging issues through its website (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/), conferences, publications, and participation in conferences.
- *Reduction of Healthcare Disparities* – CMS works to reduce racial and ethnic health disparities in Medicaid and SCHIP through identifying contributing factors and areas of opportunity, dissemination of promising practices, and forming partnerships with various agencies, private and public sector organizations, States, and other interested groups. [2]

Several of these core areas are reflected in Secretary Leavitt's initiative that challenges State Medicaid programs to partner in value-driven healthcare activities centering around four cornerstones:

- *Interoperable Health Information Technology* – States are encouraged to engage in efforts such as monitoring the activities of national standard setting bodies, working with providers toward greater utilization of electronic health records (EHR) that have been certified by national certification bodies, and participating in health information exchange (HIE).
- *Measuring and Publishing Quality Information* – States are encouraged to request that health plans use and publicly report measures adopted by recognized national bodies and to request that plans and External Quality Review Organizations (EQRO) participate in national quality transparency collaboratives. States are also encouraged to participate in national public-private collaborative committees or workgroups to establish and support standards in measuring or reporting quality and to become a member of the National Quality Forum.
- *Measuring and Publishing Price Information* – States are encouraged to make price information available to beneficiaries so that they can make more confident decisions about their health care providers and treatment options.
- *Creating Positive Incentives for High Quality Health Care Purchasers* – These could include provider incentives such as rewards for delivering high-value care, direct financial incentives and/or public recognition to providers who demonstrate superior performance, and incentives to encourage provider adoption on electronic health records and health information exchange. They could also target beneficiaries through consumer-directed health plans with a health savings account or high reimbursement account,

[2] CMS website, Medicaid and SCHIP Quality homepage, (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/)

beneficiary incentives for prevention and wellness, and provide beneficiaries with incentives for self-management of chronic illness. [3]

Medicaid and Health Information Technology

The Centers for Medicare & Medicaid Services recognizes the strategic importance of promoting the use of health information technology to advance quality of care and life. Released in August 2005, the CMS Quality Improvement Roadmap stresses the need for Medicare and Medicaid to use electronic health systems to support more effective quality improvement efforts. [4] A key element of the Medicaid/State Children's Health Insurance Program (SCHIP) Quality Strategy, issued in July 2006, is to help States enhance their health information infrastructure and improve the effectiveness and efficiency of health care delivery. [5]

On August 22, 2006, President George W. Bush signed an Executive Order to "...ensure that health care programs administered or sponsored by the Federal government promote quality and efficient delivery of health care through the use of health IT, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers". [6] Similarly, the Value-Driven Health Care initiative developed by Secretary Mike Leavitt commits the Department of Health and Human Services (DHHS) to partnerships intended to achieve the interoperability of health care information, the development of standards and a certification process to ensure that those standards are met, and the sharing of data to facilitate clinical and consumer decisions, as well as performance measurement. [7]

The Deficit Reduction Act of 2005 made $150 million available for CMS to award in support of State Medicaid transformation initiatives. One of the permissible uses of transformation grant funds enumerated in section 1903(z) of the Social Security Act is to foster the development of "methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs". The April 27, 2007 State Medicaid Directors letter soliciting State applications for a second round of transformation grants indicated that the Secretary of DHHS also encouraged States "to apply for grant funds to develop value-driven health care initiatives including systems that provide transparency in health care that allow consumers to compare the quality and price of services so they can make informed choices among doctors and hospitals". [8]

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[3] HHS website, Value-Driven Health Care/Health Information Technology, http://www.hhs.gov/valuedriven/fourcornerstones/healthit/index.html

[4] CMS website, Quality of Care Center (http://www.cms.hhs.gov/center/quality.asp)

[5] CMS website, Medicaid and SCHIP Quality homepage, (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/)

[6] Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p.16

[7] HHS website, Value-Driven Health Care/Health Information Technology, http://www.hhs.gov/valuedriven/fourcornerstones/healthit/index.html

[8] CMS website, Medicaid Transformation Grants Overview, http://www.cms.hhs.gov/MedicaidTransGrants/

Evolution of Medicaid Information Systems

In response to rapid growth in Medicaid spending during the early years of the program, Public Law 92-603 was enacted in 1972, requiring each State Medicaid Program to have an automated claims processing and information retrieval system that would facilitate accurate claim adjudication and standardized Federal reporting. While Federal prior approval of these Medicaid Management Information Systems (MMIS) and subsequent modifications was required for a State to claim enhanced Federal matching funds, Federal review tended to focus more on system outputs than on architecture, to permit States flexibility in developing customized solutions to their unique operational needs. [9] [10]

This has resulted in considerable variation among States in MMIS design and specifications, which has inhibited data sharing among State Medicaid programs and between the Medicaid agency in a given State and sister agencies. [11] Moreover, as each State automated additional program functions, the new components were often not fully integrated into the MMIS and could not easily communicate with one another because of their unique architecture, data standards, and maintenance and support elements. [12] [13] Because this claims-based system lacked clinical information and had a program rather than beneficiary-centered orientation, State Medicaid personnel were also unable to obtain meaningful information on health outcomes.[14] For these various reasons, the traditional MMIS has not been well-suited for supporting quality assessment and improvement activities.

Genesis of the Medicaid Information Technology Architecture (MITA) Initiative

In its 2001 report entitled, "Crossing the Quality Chasm: A New Health System for the 21st Century", the Institute of Medicine underscored the need for clinical information systems to be redesigned in support of evidence-based practice and improved outcomes. By sharing the data generated by such systems through health information exchanges, various stakeholders and the

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[9] Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p. 12

[10] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 7

[11] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 1

[12] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 4

[13] CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 5

[14] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 9

health care system in general can become more efficient in their operations and providers are more able to deliver patient-centered care that is coordinated and coherent. [15]

Recognizing the need to modernize State Medicaid information systems, CMS, working with States and other stakeholders, launched the Medicaid Information Technology Architecture (MITA) initiative in 2002. [16] MITA is a framework of national standards for use in developing the information systems that support a State's Medicaid Enterprise. The MITA framework is separated into three architecture components: Business Architecture, Technical Architecture, and Information Architecture.

The "Business Architecture" is generated by identifying and defining everything that a State Medicaid "enterprise" does as "Business Processes" within eight "Business Areas":

- Business Relationship Management,
- Care Management,
- Contractor Management,
- Member Management,
- Operations Management,
- Program Integrity,
- Program Management, and
- Provider Management.

Within each of these eight "Business Areas" are "Sub-Business Areas" or "Clusters". The individual "Business Processes" are defined within these "Sub-Business Areas / Clusters".

The mission of MITA is to establish a national framework of enabling technologies and processes that supports improved administration of the Medicaid program and health care outcomes for Medicaid beneficiaries. By establishing this framework, MITA seeks to move Medicaid information systems toward a greater focus on the beneficiary, integration of clinical and administrative data, support of program analysis and decision making, and an enhanced capacity for Medicaid to communicate with other programs and payers. [17]

MITA is based on the premise that interoperability works most efficiently when planned for, and built into, system designs at a very early stage. This prevents the need for more burdensome and expensive back-end fixes that are otherwise necessary to facilitate interoperability of systems for collaborative purposes, such as data exchange.

The MITA initiative is expected to lead to the development of a universal data dictionary and standard definitions of common data elements that will facilitate communications between a

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[15] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 4

[16] Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p. 13

[17] CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 3

State's core MMIS and any stand-alone systems that have been created for special operational purposes (i.e., interoperability). [18] Adoption of MITA principles is also expected to enable State Medicaid programs to participate in regional and, ultimately, national data exchange efforts. [19]

In April 2007 CMS began asking States to conduct a self-assessment, in which they document current business areas and processes and set goals to improve these processes within the MITA framework. [20] CMS plans to work with individual States to test products that further MITA principles as they become available and disseminate model approaches taken by early adopter States. [21] CMS will also revise the MMIS advance planning document (APD) review process and criteria, which States must meet before they can receive an enhanced MMIS Federal match, to assure that State information technology (IT) changes are consistent with MITA goals and objectives. These review criteria will be developed based on input from the first States to adopt MITA principles. [22]

CMSO is in the process of adding "Quality Improvement" and "Quality Measurement" to the MITA Business Architecture in the "Program Quality Management" Sub-Business Area / Cluster in the "Program Management" Business Area. When that process has been completed, State Medicaid programs can begin to include these components in their implementation of the MITA.

Nexus Between MITA and Quality

The integration of system components and interoperability of Medicaid with non-Medicaid systems can support quality improvement in several ways. By facilitating communications among systems, MITA can provide analysts with a comprehensive base of information on beneficiaries who may rely at various times on sources of coverage other than Medicaid. [23] The greater systems efficiency made possible by interoperability also enables State Medicaid programs to become aware of changes in the delivery of services in real time. [24]

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[18] CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, pp. 5-6

[19] CMS website, MITA Information Series, "The MITA Maturity Model", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 9

[20] Department of Health and Human Services Office of Inspector General Report, "State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange", issued August 21, 2007, p. 3.

[21] CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 16

[22] CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 6

[23] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", pp. 4-5

[24] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 6

With easier access to a broader picture of a beneficiary's health status and health care experience, providers are better able to reduce unnecessary testing and procedures, avoid medical errors and adverse drug events, and assure that appropriate care is delivered. This is particularly relevant for Medicaid populations with chronic conditions, physical and behavioral comorbidities, and long term care needs. [25] MITA can help Medicaid program managers identify and target at-risk populations, develop quality statistics for specific providers, and benchmark provider performance to measures calculated by other payers or States. [26]

Health Information technology and health information exchange (HIE) can also enhance the efficiency of health insurance operations. The ability to obtain clinical information quickly can enable State Medicaid agencies to expedite prior authorization decisions and thereby assure that beneficiaries receive needed services sooner. The real-time capture of provider data through HIE can also streamline the collection of Medicaid data needed for quality monitoring and improvement purposes. Linking data from Medicaid and other public programs and private payers can facilitate more accurate and efficient population-based health surveillance activity [27] and provide Medicaid managers and providers with a more complete picture of each beneficiary's medical record (e.g., immunizations).

Consistent with the DHHS Secretary's Value-Driven Health Care initiative, MITA can help State Medicaid programs develop the tools needed to increase health care transparency, such as EHRs, electronic prescribing, and personal health records (PHRs). [28] This focus can aid State Medicaid programs in developing quality standards for comparative purposes, making quality and cost information more easily available to beneficiaries, and assessing return on investment. [29]

Examples of Current State Medicaid Initiatives

In July 2007, the DHHS Office of Inspector General issued a report entitled, "State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange". The OIG found that 12 State Medicaid agencies had implemented HIT initiatives such as claims-based electronic health records, electronic prescribing, remote disease monitoring, and personal health records. Twenty-five State Medicaid agencies were involved in planning and developing Statewide HIE networks. In the context of these efforts, the OIG found that 13 State Medicaid

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[25] Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p. 15

[26] CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 7

[27] Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p.16

[28] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 1

[29] Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 9

agencies include MITA in their HIT and HIE planning. [30] The Medicaid Directors in these 13 States indicated that implementing MITA will enhance the interoperability of their MMISs, facilitate Medicaid participation in HIT and HIE initiatives, and promote quality assessment through integration of clinical information with claims-based data. [31]

In January 2007, CMS awarded 33 first-round Medicaid Transformation Grants, totaling $103 million. Eighteen of these grants, totaling $64 million, addressed HIT and HIE initiatives. [32] In September 2007, CMS awarded 17 second-round Medicaid Transformation Grants, totaling almost $52 million. Twelve of these grants, totaling nearly $37 million, addressed HIT and HIE initiatives. Summary information and grant applications for each initiative can be found on the CMS website at http://www.cms.hhs.gov/MedicaidTransGrants/02_2007awards.asp#TopOfPage.

Various State HIT, HIE, and MITA related initiatives are also referenced in the individual State quality packets disseminated in response to the CMS goal of increasing "the number of States that have the ability to assess improvements in access and quality of health care".

Future Opportunities and Next Steps

CMS encourages State Medicaid programs to work toward incorporating MITA principles that will enable them to implement initiatives that can enhance the quality of care and life for their beneficiaries. As CMS indicates in responding to MITA Frequently Asked Question FC-003, "the true litmus test for making the business case for MITA will depend upon the extent to which it contributes to improving overall health outcomes and reduces overall health expenditures on behalf of Medicaid beneficiaries." [33]

CMS intends to take a series of concrete actions to explore opportunities for using MITA principles to advance quality goals for Medicaid beneficiaries. Initial steps will include the following:

- Develop a task force composed of State Medicaid Directors, Medicaid Medical Directors, and information technology and quality professionals
- Conduct an assessment of how States are currently using the MMIS or other data systems to support Medicaid quality and disseminate promising practices
- Determine gaps in transparency of quality and cost data to support ends, such as provider assessment, consumer choice, and reporting

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[30] OIG News press release, "OIG Issues Report on State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange", August 21, 2007.

[31] OIG Report, "State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange", issued August 21, 2007, p. 14-15.

[32] OIG Report, "State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange", issued August 21, 2007, p. 4.

[33] CMS website, Medicaid Information Technology Architecture (MITA), "MITA Questions", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAQuestions.asp#TopOfPage
p. 12

- Decide actions that can be taken to improve transparency
- Provide States with technical assistance through the joint efforts of CMS systems and quality staff
- Convene joint conference calls of standing systems, quality, and managed care Technical Advisory Groups to address issues impacting the re-engineering of Medicaid systems for quality purposes

Tab G

Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations - Iowa

Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations - Iowa

Transformation Grants

Iowa does not have a Transformation Grant award at this time.

CMS-Posted Promising Practices

Iowa has no promising practices on the CMS Medicaid/SCHIP Quality website or the Survey and Certification website. We encourage Iowa to submit descriptions of any innovative initiatives that advance quality for Medicaid beneficiaries or SCHIP enrollees using the guidelines and format found at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNomination%20Process.asp#TopOfPage. See http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage for examples of promising practices for other States already posted to this site.

Iowa has the following promising practice profiled on the CMS Home and Community Based Services promising practices website (http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp#TopOfPage):

Iowa – Retaining and Recruiting Direct Support Professionals

Issue: Training, Mentoring and Increasing Awareness of Direct Support Professionals

Like many states, Iowa is experiencing high turnover rates for direct support professionals in both institutions and in the community. The average turnover rate of direct care workers in nursing facilities in Iowa is 60-80% and has been reported as high as 200% in some facilities. The turnover rate for Home Health Aides is 40-60%. High turnover rates cost money, cause people's support to be inconsistent, and decrease the quality of life of persons with disabilities. Meanwhile, the need for direct support professionals in the community is steadily increasing as more people seek home and community-based services.

The Iowa CareGivers Association (ICA) implemented a Certified Nursing Assistant (CNA) Recruitment and Retention Project to decrease turnover among CNAs who provide direct support in three Northwest Iowa nursing facilities. ICA is a member-driven association that provides education, information, support, and advocacy for CNAs, Home Health Aides, and other specialized direct support professionals. The project targeted nursing facility staff, but a similar approach may work with direct support professionals in the community.

The National Resource Center for Family Centered Practice at the University of Iowa's School of Social Work evaluated the project in December 2002. The evaluation found that facilities that provided CNA in-service trainings, support groups, and CNA mentorship opportunities had an average length of CNA employment of 18.96 months, which was significantly higher than the control group average of 10.01 months. The CNAs in the treatment group also reported greater job satisfaction.

Recognition by Other Health-Related Organizations

Self-Directed, Self-Controlled Budget for Personal Assistance Services Reduces Unmet Needs, Improves Quality of Life for Medicaid Beneficiaries

Medicaid consumers sometimes face obstacles when seeking home care from State-contracted agencies, and as a result they might receive few or none of the personal assistance services they need or are authorized to receive. Cash & Counseling provides frail elderly and disabled individuals of all ages with Medicaid coverage with an annual budget, letting the individuals decide and pay for the combination of goods and services that best meets their personal care needs. Cash & Counseling participants may use their budgets to hire their own personal care aides, including friends or relatives, and to purchase items and services that will help them to live independently.

The original Cash & Counseling demonstration, supported by the Robert Wood Johnson Foundation and implemented as section 1115 Medicaid demonstrations, was conducted in Arkansas, New Jersey, and Florida beginning in 1998. When these states applied for and received grants to implement Cash & Counseling, there was little evidence that consumers could or would successfully direct their own personal care services. Advocates were passionate and policymakers were intrigued, but the idea had not been rigorously tested. Cash & Counseling tested its results, which were so positive that program funders provided grants for replication in 11 more states in 2004. In that same year the Retirement Research Foundation provided additional funding to replicate the Cash & Counseling model in Illinois.

A randomized controlled trial comparing Cash & Counseling with traditional agency-directed care in Arkansas, Florida, and New Jersey found that the program resulted in increased use of personal care services, significantly fewer unmet personal care needs, and improved the quality of life for participants and caregivers; in addition, the program did not increase (and sometimes reduced) the risk of adverse health outcomes, and did not result in the misuse of Medicaid funds or the abuse of consumers.

Source: AHRQ Health Care Innovations Exchange
(http://www.innovations.ahrq.gov/content.aspx?id=1800)

Tab H

CMS Regional Office Reviews of Iowa
Home and Community Based Services Waiver Programs

(Note: This tab includes the Executive Summaries of, or excerpts of the recommendations from, the CMS Regional Office Review Reports. The complete final reports are available upon request.)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region VII

FINAL REPORT

Home and Community-Based Services Waiver Review
Iowa Elderly Waiver Program
IA 4155.90.R3

Conducted July 10, 2007

Home and Community-Based Services
Waiver Review Report

Executive Summary:

- The Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME), is the single state agency that retains administrative authority of Iowa's Home and Community-Based Services Waiver (HCBS) for the Elderly (IA 4155). This waiver allows for the provision of services to individuals aged 65 and older meeting the nursing facility level of care (LOC). It was initially approved in 1990 and currently serves 8,703 individuals. The approximate average cost per person is $4,536.

- As requested per the CMS Interim Procedural Guidance, Iowa submitted evidence to demonstrate that the State is meeting the program assurances as required per 42 CFR 441. In its submission of April 2, 2007, the State provided an introduction to its overall monitoring framework and various examples and summary reports specific to each assurance. After review of the information, an onsite visit was scheduled for July 10, 2007, to provide an opportunity for further clarification and demonstration of system processes, and actual participation in quality activities.

  Iowa is in the midst of reviewing and revising its quality assurance activities after evaluating the system in 2006. A new quality improvement plan, "Inclusion through Quality" is in various stages of implementation. The plan includes the development of a Quality Management Oversight Structure. The CMS review team observed both the Quality Management Committee and the Incident Reporting/Complaint Workgroup meetings while onsite. Both meetings are part of this oversight structure.

  The State has contracted quality oversight for all of its waiver programs to Iowa State University (ISU). The State is divided into ten regions, with an HCBS Specialist assigned to each. The HCBS Specialists provide monitoring, training, and technical assistance for the waiver programs. An HCBS Supervisor and QA Specialist are also part of the overall structure. A conference call was held with these individuals during the onsite to discuss their roles and responsibilities, training provided, and their perspective of both provider and consumer issues they are finding in day to day activities in the field.

  Iowa utilizes a web-based program called the "Individualized Services Information System", or "ISIS" to support its waiver programs. This tool functions as a remediation of sorts in that the system creates a workflow, identifying milestones that must be completed before further action can take place. ISIS provides documentation (i.e., LOC determinations, service plans), provider information (i.e., certifications, provider lists), and management reports (i.e., tracking workflow, program statistics), to name a few of the functions. ISIS

continues to be modified and enhanced to incorporate improvements as necessary for oversight of the program. CMS was provided a demonstration of ISIS during the onsite visit.

- Summary of Findings:

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization - State substantially meets the assurance.

    - CMS has no recommendations at this time.

2. Service Plans are Responsive to Waiver Participant Needs - The State demonstrates the assurance but CMS recommends improvements or requests additional information.

    - CMS encourages the development of a formal process to document that consumers are afforded choice between institutional care and home and community-based waiver services. This process should also be included in the State's monitoring activities to assure that consumer choice is being provided.

3. Qualified Providers Serve Waiver Participants - The State substantially meets the assurance.

    - CMS has no recommendations at this time.

4. Health and Welfare of Waiver Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.

    - CMS recommends Iowa move forward in its efforts to develop a consistent incident reporting management process that includes the Elderly Waiver program.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

    - CMS recommends a formal written document be created that can be used as an action plan to guide and consolidate the various activities of "Inclusion through Quality" into one central source. A plan that sets forth timeframes for defined actions, prioritizes activities, and establishes next steps when necessary, would enhance the State's oversight of its waiver programs.

6. State Provides Financial Accountability for the Waiver – The State substantially meets the assurance.
    - CMS has no recommendations at this time.

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region VII

FINAL REPORT

Home and Community-Based Services Waiver Review
Iowa Physical Disability Review
Iowa – 0345.90
November 29, 2006

Home and Community-Based Services

Waiver Review Report

Summary of Findings and Recommendations:

I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, NF, or ICF/MR. Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets this assurance X

Recommendations:

None

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

The State substantially meets this assurance X

Recommendations:

It is recommended that the State continue with its efforts in the development and implementation of its QA process by documenting the issues and trends identified through analysis of data collection and what follow-up occurs as a result.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Authority: 42 CFR 441.302; SMM 4442.4

The State substantially meets this assurance X

(The State has an adequate and effective system for qualifying and monitoring providers, and demonstrates ongoing, systemic oversight of providers.)

Recommendations:

As the oversight entity, the State of Iowa reviews and maintains authority of the waiver program. The State is responsible for monitoring training and taking action when providers do not meet requirements. The State meets this assurance; however, we recommend a few improvements. Documentation provided shows that while the State is tracking overall waiver systems, much of the data in Quarterly Summaries and Reviews are not broken down by specific waiver type. It is recommended that the State continue to pursue ways to focus reviews and monitoring to the PD waiver population. This will better allow the State to trend and analyze performance for the waiver in order to continually improve the program.

CMS recommends that Iowa continue their efforts to improve oversight of CDAC providers. Iowa has made improvements in this area over the past years. It is encouraged that the State continue to focus on improvements in oversight of non-licensed providers to ensure sufficient protections of waiver participants.

Evidence provided indicates that trainings held for HCBS providers focus primarily on processes. It is recommended that the State consider providing training specific to the PD Waiver. Separation of waiver data will assist the State in recognizing needed areas for training.

Such processes will better allow the state to practice oversight of providers and to provide training appropriate to individual provider needs, thus ensuring the highest quality of service to participants.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State substantially meets this assurance X
(While the State may not have a full and comprehensive system to assure health and welfare, the systems in place are adequate and effective and the State demonstrates ongoing, systemic oversight of health and welfare; improvements may still be necessary)

Recommendations:

It is recommended that the State continue with its efforts in the development of the new incident reporting process, which includes reports documenting the issues and trends identified through analysis of data collection and what follow-up occurs as a result.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application. Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM4442.7

The State substantially meets this assurance X
(The State Medicaid agency has an adequate and effective system for administrative oversight of the waiver, and the administration of the waiver program is consistent with the approved waiver.)

Recommendations:

Iowa indicated that informal meetings for monitoring purposes occur between the State and IFMC. CMS recommends the State formalize these meetings and document the discussions through meeting minutes to help identify issues and follow-up actions.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets this assurance X
(While the State may not have a full and comprehensive approach to assuring financial accountability, the system in place is adequate and the State demonstrates ongoing, systemic oversight; improvements may still be necessary)

Recommendations:

None

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region VII

Final Report

Home and Community-Based Services Waiver Assessment
Iowa HIV/AIDS
Control 0213.90.R1.03
Date Report Issued:

June 17, 2005

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Home and Community-Based Waiver Services

(Iowa HIV/AIDS Waiver) Assessment Report
Control # 0213.90.R1.03

Summary of Findings and Recommendations:

I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, nursing facility or ICF/MR. Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5; SMM 4442.6

The State does not substantially meet this assurance
(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)

Recommendations:

(Required – when the State does not substantially meet this assurance.)

Based on previous reviews, CMS staff is familiar with the ISIS system and reports. Because this is an evidentiary review, it is necessary for the State to provide the evidence to support the process. At this point, CMS do not have the evidence needed therefore we cannot validate that the State is meetings this assurance and are requesting a corrective action plan.

The CORRECTIVE ACTION PLAN should include that the State develop a formal process to monitor and provide oversight to IFMC. This will help the State in assessing any LOC changes or determinations made, which also directly correlates to the client's POC. This process should include the production of ISIS reports to document LOC determinations are being done timely and correctly. CMS requests the State provide this process within 6 months. Some examples of evidence that CMS is requesting along with the process include:

a) Quarterly Report that IFMC provides to the State showing number of determinations and reassessments. The purpose of this report is to demonstrate the State is monitoring contract compliance.

b) ISIS generated report that demonstrates the timeliness of assessments and reassessments.

c) Documentation that a supervisory review is done at IFMC to demonstrate that they are checking for accuracy.

Also, CMS recommends that the State and IFMC work more closely together on devising a more inclusive summary regarding their actual LOC evaluation and determination process that also reflects their findings, recommendations, and actions taken at their quarterly meetings. CMS requests the State and IFMC prepare formal minutes on a quarterly basis of their meetings. CMS also suggests using the QA committee meetings as an avenue to analyze findings, recommendations, actions taken, and follow-up. CMS requests the State send on a quarterly basis the QI committee meeting minutes.

CMS also recommends the State update the quarterly summaries reporting procedures for HCBS specialists to collect data by each specific waiver.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented a system to assure that plans of care for waiver participants are adequate and services are delivered and are meeting their needs.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

1 The State does not substantially meet this assurance
(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)

Recommendations:
(Required – when the State does not substantially meet this assurance.)

For the State to meet this assurance, CMS is requesting a CORRECTIVE ACTION PLAN for the State to implement a process to monitor and document that the POCs are updated, revised when needs and/or services change, and that problems have been resolved. CMS requests the State develop a process which includes reporting documentation on how they will begin to monitor and document the changes that need to occur to consumer's POCs. CMS requests the State provide this process within 6 months. The process should include the following:

a) Segregated data for AIDS consumers;
b) Reports with analysis of data ;
c) Summaries of data analysis;
d) Documentation of discussion and recommended actions on the part of the State to address findings that do no meet the threshold or that are unacceptable
e) Follow-up actions taken and documented
f) Report, including analysis, concerning the satisfaction survey of all consumers interviewed
g) QI monitoring results from monitoring for abuse, neglect, and exploitation; and complaints of and by AIDS waiver consumers.
h) Summaries of incident reports that are reported to the QA committee
i) Reports and analysis, actions, and follow-up of Iowa IFMC monitoring findings.

It is also recommended that the State continue the QA Committee meetings. CMS suggests the State use their QA Committee meetings to report monitoring findings and data and analyze and trend this information. As stated in the previous section, CMS requests the State send on a quarterly basis the QA committee meeting minutes.

It is recommended that the State develop a system whereby consumers are given a comprehensive list of providers they may choose from. This could be a current provider listing on the State website, or information that could be provided during annual consumer assessments. CMS requests a timeline and will follow-up with the State within 6 months to document progress.

The regional office would also like to offer technical assistance to the State in developing a more comprehensive quality assurance plan. This may include topics such as reporting mechanisms, analyzing data, and general State oversight. Additionally, please consider utilizing CMS' contractor, Medstat, to assist you in this process.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Authority: 42 CFR 441.302; SMM 4442.4

The State substantially meets this assurance X
(The State has an adequate and effective for qualifying and monitoring providers, and demonstrates ongoing, systemic oversight of providers.)

Recommendations:

CMS recommends the State formally document the process for monitoring providers on a periodic basis, to ensure they meet required licensing and/or certification standards and adhere to other State standards. In addition, the State should track the number of AIDS/HIV providers selected annually for certification review and maintain written documentation of the provider certification reviews. This documentation would demonstrate the State is monitoring oversight and provide data that could be aggregated and trended for QA purposes. This data could then be taken to the QA committee to improve the overall quality of the waiver as it relates to waiver providers. CMS requests the State provide a timeframe for the completion of these recommendations.

It is also recommended the State QA Committee develop a QA process to monitor complaints as a whole from all sources including the local level. CMS requests to see a timeline for this process as well evidence of the process such as written rules and data collected and will follow-up with the State within 6 months to document progress.

The State should also modify the complaint log to include columns to identify the specific waiver, type of complaint, follow-up action taken, and a designation that the

complaint committee has reviewed the complaint. The complaint committee should meet on a regular basis and generate a report quarterly of the summary of findings and actions taken to resolve the complaints and the report should be taken to the QA committee to review for QA/QI purposes. CMS request a timeframe for the completion of these tasks.

As stated in the LOC section, it is recommended the State update the quarterly summaries reporting procedures for HCBS specialists to collect data by each specific waiver. The data can then be aggregated and trended for by specific waiver for QA/QI purposes to make recommendations to improve the overall quality of the waiver provider oversight.

The State should also document and implement a formal oversight plan of licensed and non-licensed providers into their QA/QI plan. This oversight will provide documentation that providers are monitored on periodic basis to provide sufficient protections to waiver participants. In addition, the State will be able to assess and identify specific training needs specific with regard to CDAC services.

CMS recommends the State develop a system for tracking provider training for monitoring purposes. CMS also recommend the State provide AIDS/HIV disease specific training to providers and provide documentation to CMS of the completion of this training such as training materials, and agenda.

VI. Health and Welfare of Waiver Participants

The State must demonstrate that it assures the health and welfare of waiver participants including identification, remediation and prevention of abuse, neglect and exploitation.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 447.200; SMM 4442.4; SMM 4442.9

The State substantially meets this assurance X
(The State's system to assure health and welfare is adequate and effective, and the State demonstrates ongoing, systemic oversight of health and welfare.)

Recommendations:
(Not all States that substantially meet this assurance will have full and comprehensive systems to assure health and welfare; improvements may be warranted.)

As stated in the qualified provider section, it is recommended that a mechanism be established at the local level for DHS to formally track all complaints. There should be a process in place that reports to the Department what complaints are received, what actions are taken, what follow-up occurred, and what referrals were made to the complaint committee. The State should also be able to separate complaints and documentation for each waiver to ensure that there is monitoring and evidence of assurance of health and welfare for waiver participants in each specific waiver. CMS requests a written plan and timeline for this process and will follow-up with the State within 6 months to document progress.

Also, the State should implement a formal process to track deaths for AIDS/HIV waiver consumers and document and report the results to the QA committee to analyze and act upon. CMS requests the State provide a timeline for the completion of this task.

It is also recommended that the State implement the plans for a future rule to include all incident reporting for all waivers. CMS requests the State to provide a timeframe for this action and follow-up based on the timeframe provided.

The State should continue to design a process to track and trend HCBS complaints received through the new hotline for follow-up. CMS requests the State provide a timeline for completion of this task.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.

Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State substantially meets this assurance X
(The State Medicaid agency has an adequate and effective system for administrative oversight of the waiver, and the administration of the waiver program is consistent with the approved waiver.)

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 42 CFR 447.200; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets this assurance X___
(The State's system for assuring financial accountability is adequate and the State demonstrates ongoing, systemic oversight of waiver finances.)

Tab I

DATA FROM CMS HOSPITAL COMPARE AND NURSING HOME COMPARE DATABASES

HOSPITAL MEASURES			
		IOWA	**USA**
	Surgery Measures		
1	Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision	85%	83%
2	Percent of Surgery Patients Who Received the Appropriate Preventative Antibiotic for Their Surgery	91%	90%
3	Percent of Surgery Patients Whose Preventative Antibiotics are Stopped Within 24 Hours after Surgery	80%	80%
4	Percent of Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots From Certain Types of Surgeries	81%	80%
5	Percent of Surgery Patients Who Received Treatment to Prevent Blood Clots Within 24 Hours Before or After Selected Surgeries to Prevent Blood Clots	78%	76%
	Myocardial Infarction		
1	Percent of MI Patients Given Aspirin at Arrival	91%	93%
2	Percent of MI Patients Given Aspirin at Discharge	87%	91%
3	Percent of MI Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction	91%	87%
4	Percent of MI Patients Given Smoking Cessation Advice/Counseling	95%	92%
5	Percent of MI Patients Given Beta Blocker at Discharge	92%	91%
6	Percent of MI Patients Given Beta Blocker at Arrival	89%	89%
7	Percent of MI Patients Given Fibrinolytic Medication Within 30 Minutes of Arrival	51	39%
8	Percent of MI Patients Given Percutaneous Coronary Interventions Within 90 Minutes of Arrival	76%	63%
	Pneumonia Measures		
1	Percent of Pneumonia Patients Given Oxygenation Assessment	100%	99%
2	Percent of Pneumonia Patients Assessed and Given Pneumococcal Vaccination	84%	77%
3	Percent of Pneumonia Patients Whose Initial ER Blood Culture was Performed Prior to the Administration of the First Hospital Dose of Antibiotics	92%	90%
4	Percent of Pneumonia Patients Given Smoking Cessation Advice / Counseling	75%	85%
5	Percent of Pneumonia Patients Given Initial Antibiotic within Six Hours After Arrival	96%	93%
6	Percent of Pneumonia Patients Given the Most Appropriate Initial Antibiotic	87%	87%

7	Percent of Pneumonia Patients Assessed and Given Influenza Vaccination	84%	75%
	Heart Failure Measures		
1	Percent of Heart Failure Patients Given Discharge Instructions	63%	68%
2	Percent of Heart Failure Patients Given an Evaluation of Left Ventricular Systolic Function	78%	86%
3	Percent of Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction	84%	85%
4	Percent of Heart Failure Patients Given Smoking Cessation Advice / Counseling	83%	88%

NURSING HOME MEASURES

Measures	Average in Iowa	National Average
Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season	90%	88%
Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	95%	87%
Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	15%	16%
Percent of Long-Stay Residents Who Have Moderate to Severe Pain	4%	4%
Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	8%	12%
Percent of Low-Risk Long-Stay Residents Who Have Pressure Sores	2%	2%
Percent of Long-Stay Residents Who Were Physically Restrained	2%	5%
Percent of Long-Stay Residents Who are More Depressed or Anxious	17%	14%
Percent of Low-Risk Long-Stay Residents Who Lose Control of Their Bowels or Bladder	43%	50%
Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	7%	6%
Percent of Long-Stay Residents Who Spend Most of Their Time in Bed or in a Chair	1%	4%
Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	12%	13%
Percent of Long-Stay Residents With a Urinary Tract Infection	9%	9%
Percent of Long-Stay Residents Who Lose Too Much Weight	8%	9%
Percent of Short-Stay Residents Given Influenza Vaccination During the Flu Season	86%	77%
Percent of Short-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	89%	79%
Percent of Short-Stay Residents With Delirium	3%	2%
Percent of Short-Stay Residents Who Had Moderate to Severe Pain	25%	20%

Percent of Short-Stay Residents With Pressure Sores	11%	16%

Tab J

2007 State Children's Health Insurance Program (SCHIP) Data: Iowa

2007 State Children's Health Insurance Program (SCHIP) Data: Iowa

In order to measure improvement in the delivery of, access to and quality in the State Children's Health Insurance Program (SCHIP), in 2003, States began collecting data on four core clinical performance measures: (1) well child visits in the first 15 months of life; (2) well-child visits in the third, fourth, fifth, and sixth years of life, (3) use of appropriate medications for children with asthma; and, (4) Children's access to primary care practitioners.

Iowa reported data for all four core measures. Rather than report the percent of children who received a specific number of well child visits in the first 15 months, the State reported the percent who received at least one such visit. The rate for this measure increased by 8.5 percentage points between 2006 and 2007.

The rates of Well Child Visits for Children in the 3rd, 4th, 5th, and 6th Years of Life declined between 2005 and 2007 for 4- and 5-year olds. The percent of 6-year olds receiving well child visits was quite low for each of the 3 years reported.

The percent of children in each age group measured who used appropriate asthma medications rose consistently and considerably over the three-year period, 2005-2007. Childen's Access to a PCP declined noticeably between 2005 and 2007 for 12-24 month-old children. Rates for the other three age groups reported changed little over the three years reported. The lowest rates over the 3-year period were reported for the age group, 25 months to 6 years.

We would appreciate the State's efforts to provide the percent of children in the first 15 months who receive specific numbers of visits. We would also appreciate additional information to explain the low rates and downward trends in certain measures, discussed above. We will be glad to provide technical assistance to enhance the State's reporting of each of these measures.

Well Child Visits in First 15 Months (W15)

Visits	2005	2006	2007 **
0	*	*	*
1	55.2%	53.2%	61.7%
2	*	*	*
3	*	*	*
4	*	*	*
5	*	*	*
6	*	*	*

* State reported only the number of children who had one or more well-child visits

** Claims were expanded to include in this measure from a five to seven month timeframe surrounding the date the child turned 15 months of age.

Well Child Visits for Children in the 3rd, 4th, 5th, and 6th Years of Life

Age	2005	2006	2007 **
3	47.3%	46.6%	49.9%
4	58.7%	59.3%	55.9%
5	62.2%	61.2%	58.2%
6	22.5%	19.8%	21.6%

Use of Appropriate Asthma Medications (ASM)

Age (yrs)	2005	2006	2007
5-9	66%	75%	85%
10-17	56%	63%	86%
5-17	60%	68%	86%

Children's Access to PCP (CAP)

Age (mo/yrs)	2005	2006	2007
12-24 mo	95%	90%	88%
25 mo-6 yrs	87%	88%	86%
7-11	92%	92%	93%
12-19	94%	94%	94%

Medicaid Value Management Program
SFY 2008 Report
Executive Summary

In SFY 2007 the Medicaid Value Management (MVM) program was developed under the direction of the Iowa Medicaid Director to establish a more comprehensive approach for improving the quality and value of medical services to Iowa Medicaid members. Medical Services Unit provided the leadership for the program development and implementation. Program goals are to:

- Compare nationally recognized benchmarks and data on utilization of services, gaps in care and to evaluate the Medicaid program and services in Iowa.
- Conduct a periodic evaluation utilizing the various data sources to identify opportunities to improve the balance of healthcare quality, service and cost for the Iowa Medicaid program.
- Through analysis of data, develop recommendations to add value to programs and services for the Medicaid member.

The Vision for the Iowa Medicaid Value Management program is to:

Maximize the value of the program to Medicaid members within the fiscal limitations of the state and federal budget.

The Medicaid Medical Director leads the MVM team in the evaluation and analysis of program data and developing projects with potential for enhancing quality of services and/or cost savings. Projects are staffed by Medical Services and may include other IME vendors such as the Surveillance and Utilization Review (SURS), Provider Services, Department of Human Service (DHS) Policy Specialists and Data Warehouse staff. Representatives of the MVM team meet with the Medicaid Director monthly to review and discuss status of the projects.

MVM projects in SFY 2008 included:

- Correct coding initiative
- Healthcare Cost and Utilization Program - Prevention Quality Indicator analysis
- MRI/CT expenditure trends
- Claims review analysis from SFY 2002-2007

All of the projects are developed with regard to long-term sustainability, potential impact on health outcomes and potential impact on costs. Iowa Medicaid data for selected projects will be periodically compared to industry standards and quality benchmark data. Comparison results outside an expected range (exceptions) will provide indications of target areas for further investigation and potential improvement.

MVM priority activities for SYF 2009 include:

- Quarterly review and follow up with PQI results
- Analysis of claims with missing or unknown diagnostic information to promote transparency for Medicaid expenditures
- Analysis of incidents of low birth weight and maternal health care with a goal of improving outcomes

Medicaid Value Management Program

SFY 2008 Report

Background

The Iowa Medicaid Enterprise (IME) has a number of activities and processes that provide controls and program management information. These controls and processes are carried out by multiple IME vendors and are a coordinated effort to provide system integrity. The following table summarizes the inventory of controls and processes.

Program Controls	Processes
Utilization Management	DUR
	Level of care (LOC) determinations
	Prior authorization
	MDS validation
	Remedial plan review
Program Integrity	Processes
	SURS
	MMIS claim edits
	Correct coding initiative
	Retrospective review
	Claims pre-pay review
	Lock-in/Lock-out programs
	Provider verification and enrollment
Program Transparency	Processes
	Performance measures scorecard
	Monthly, quarterly & annual reports

While these processes and activities provide significant program management information they do not provide a systematic review of the quality and value of services provided. In SFY 2007 the Medicaid Value Management (MVM) program was developed under the direction of the Iowa Medicaid Director to establish a more comprehensive approach for improving the quality and value of medical services to Iowa Medicaid members. The Medical Services Unit provided the leadership for the program development and implementation. Program goals are to:

- Compare nationally recognized benchmarks and data on utilization of services, gaps in care and to evaluate the Medicaid program and services in Iowa.
- Conduct a periodic evaluation utilizing the various data sources to identify opportunities to improve the balance of healthcare quality, service and cost for the Iowa Medicaid program.
- Through analysis of data, develop recommendations to add value to programs and services for the Medicaid member.

The Vision for the Iowa Medicaid Value Management (MVM) program is to:

Maximize the value of the program to Medicaid members within the fiscal limitations of the state and federal budget.

Projects initiated in the first year of MVM included the following:

- Utilizing established Healthcare Cost and Utilization Program (HCUP) information, primarily the Prevention Quality Indicators, developed by Agency for Healthcare Quality and Research and Healthcare Effectiveness Data Information Set (HEDIS) as benchmark data
- Correct coding initiative with informational letters to providers regarding their coding practices that were greater than two standard deviations from the norm
- Tracking and trending MRI/CT costs and utilization over the past three fiscal years to study appropriateness of prior authorization
- Trending exceptions to policy (ETP) approvals and denials to determine if a policy change for services with a high percentage of approvals should be a covered benefit
- Development of claims review protocols based on the ICD-9 CM for in-depth analysis to isolate and identify the variables in utilization and costs that they might be addressed in future program/policy changes.

MVM Projects

The Medicaid Medical Director leads the MVM team in the evaluation and analysis of program data and developing projects with potential for enhancing quality of services and/or cost savings. Projects are staffed by Medical Services and may include other IME vendors such as the Surveillance and Utilization Review (SURS), Provider Services, Department of Human Service (DHS) Policy Specialists and Data Warehouse staff. Representatives of the MVM team meet with the Medicaid Director monthly to review and discuss the status of the projects.

MVM projects in SFY 2008 included:

- Correct coding initiative
- Healthcare Cost and Utilization Program - Prevention Quality Indicator analysis
- MRI/CT expenditure trends
- Claims review analysis from SFY 2002-2007

Correct Coding Initiative

This initiative analysized claims data to evaluate provider billing practices. With the assistance of the Service Utilization Review staff (SURS), the MVM team created a database to track provider billing. The codes used for the project were evaluation and management (E/M) codes 99211 through 99215, which cover physician office visits for established patients. These codes were chosen because of a 2002 study done by the Office of the Inspector General (OIG) that found more than 35% of E/M codes billed at higher levels did not meet the requirements for these levels. In SFY 2008, 206 providers identified as billing at levels two standard deviations above the norm were sent letters detailing the findings. The letters reminded the providers that IME has the option of reviewing any claim or medical record and that if errors are found recoupment may occur. The letter also included a statistical breakdown of the typical Medicaid coding distribution looks for E/M codes 99211-99215. Of the 206 letters sent, 37 providers completed return correspondence explaining their coding practices.

Data from the initial correct coding sample from SFY 2007 suggested that with the prevalence, and the total amount of money spent annually on E/M, it may be possible to save Iowa Medicaid close to $200,000 a year. This initiative was an inexpensive educational intervention and designed to give feedback on coding practices.

This project will be continued with a review of SFY 2008 claims in 2009 to determine if this approach had an impact on coding practices and should then be continued.

Preventive Quality Indicators (PQI) Analysis

MVM team utilizes the Quality Indicators (QI) developed by the Agency for Healthcare Research and Quality (AHRQ) including Prevention Quality Indicators (PQIs), Inpatient Quality Indicators (IQIs) and Pediatric Quality Indicators (PDIs) as comparison data. These indicators are part of the HCUP data. HCUP is a family of health care databases and related software tools and products. HCUP is based on statewide data collected by hospitals across the United States.

After using claims to calculate the QIs, the team established 95% confidence intervals for each QI. In comparing Iowa Medicaid data to the HCUP data, the goal is to see the Iowa Medicaid rates falls within or below the confidence intervals. This would indicate that the quality of care for the Iowa Medicaid membership is at or above the aggregate rates of the other states participating in HCUP. The report on the following page reflects the PQIs for IME SFY 2007. The highlighted quality indicators reflect those that are of some concern. A PQI is highlighted if the IME rate is above the comparison rate. A QI is also highlighted if the comparison measure is within or below the IME confidence interval (this is because the comparison rate reflects the 50^{th} percentile nationally). A PQI may also be highlighted if there was an increase in the rate from SFY 2006 to SFY 2007 or if it is likely related to another area of potential concern.

Comparison results outside an expected range or with adverse movement (highlighted areas) provide indications of target areas for potential improvement. These target areas will be the focus of further assessment and analysis. Assessment and analysis will include further drill-down into the data, (e.g., by age group, by aide type, by provider, by region, etc). This assessment and analysis will lead to the development of recommendations for intervention.

Prevention Quality Indicators SFY 2007						
PQI	IME Numerator	IME Denominator	IME Rate/100,000	95% CI IME Indicator	Comparison Rate/100,000	Change from '06 %
Diabetes Short Term Complications	258	236,873	108.9	95.4-122.4	54.74	3.5
Perforated Appendix	30	120	25.0	16.8-33.2	30.17/100	4.2
Diabetes Long Term Complications	224	236,873	94.6	81.9-107.2	126.82	11.1
COPD	302	236,873	127.5	112.9-142.1	230.37	-6.5
Hypertension	60	236,873	25.3	18.7-31.9	49.70	-0.4
Congestive Heart Failure	337	236,873	142.3	126.9-157.7	488.56	-2.1
Low Birth Weight	971	4,104	6.0	5.6-6.4	6.26/100	3.2
Dehydration	132	236,873	55.8	46.0-65.4	127.35	-15.5
Bacterial Pneumonia	543	236,873	229.2	209.8-2548.7	418.18	13.0
Urinary Tract Infection	274	236,873	115.7	101.8-129.6	177.27	10.4
Angina	29	236,873	12.3	7.6-16.9	45.92	-31.0
Diabetes Uncontrolled	44	236,873	18.6	12.0-24.3	22.24	73.8
Adult Asthma	257	236,873	108.5	95.0-121.9	120.57	2.3
Lower Extremity Amputation	55	236,873	23.2	16.9-29.6	39.09	0.0
Overall PQI	2,475	236,873	1,044.9	1003.7-1086.0	1,878.51	3.0
Acute PQI	949	236,873	400.6	374.9-426.3	722.80	7.4
Chronic PQI	1,526	236,873	644.2	611.8-676.7	1,155.84	0.5

The team focused on results of the PQIs to identify red flag issues related to quality of care and need for further inquiry. The PQIs are a set of 14 indicators based on hospital discharge data that identify hospitalizations that may have been prevented if the member had received better outpatient care.

PQIs are currently run every quarter utilizing claims data and represent a rolling 12 months of data that is compared to the past three years of claim data. In SFY 2008 MVM identified the following performance indicators for further analysis and investigation:

- PQI-1 Diabetes Short-term Complications Admission Rate
- PQI-2 Perforated Appendix Admission Rate
- PQI-3 Diabetes Long-term Complications Admission Rate
- PQI-14 Uncontrolled Diabetes Admission Rate

PQI Status Reports – Performance Indicator Checklists

The following series of checklists provide detail on activities and results of analysis completed by the MVM team.

PQI-1 Diabetes Short-term Complications Admission Rate

Rationale for PQI selection: Instead of simply looking at how many people had complications from short-term diabetes, the ratios take into account population growth. The ratios reflect what the raw numbers showed; specifically that there is a growing diabetes problem in the Iowa Medicaid population. Further analysis was needed to identify trends in the state by demographics, providers, or other factors.

Numerator: All non-maternal/non-neonatal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma)

Denominator: Population in metro area or county, age 18 years and older.

Population/Demographics

☒ Age	18 years of age and older - This is a younger population of individuals; most of the recipients (38%) are under the age of 30 and 62% are under the age of 40
☒ Gender	The gender distribution is equal
☒ County of Residence	As the data would suggest, the service areas with the biggest increases in short-term diabetes complications were: Council Bluffs; Davenport; Cedar Rapids. (NOTE: The growth in these areas is not attributable to overall population growth; ratios were computed to assess indicator growth independent of population growth)

Program Variables

☒ Coverage Group	
☒ Aid Type	The largest increases by aid type were: Iowa Care 200% group for people ages 19 to 64(60E); Medically Needy under Family Medical Assistance related coverage or under SSI related coverage(37E); Disabled Receives Mandatory State Supplementary Assistance(640); Family Medical Assistance Program(308)
☐ Service Area	
☐ Waiver Type	

Provider Data

☒ Provider Type	
☒ Provider Name	The providers that saw the largest increases were: Alegent Health Mercy Hospital (Council Bluffs); Genesis Health System (Davenport); Mercy Hospital Medical Center (Cedar Rapids). (NOTE: UIHC and Broadlawns had large increases but these were most likely tied to the growth of the IowaCare program)

Claims Specific Data

☒ Diagnosis Code/Description	25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033
☐ Paid Date/Date of Visit	
☐ Claim Type (Inpt, Outpt, etc.)	
☐ Procedure Code/Description	The overall increase in this indicator was largely driven by complications from Ketoacidosis; this diagnosis accounted for 57% of all the short-term complications
☐ Cost	
☒ Exclusions	Exclude transfers from another institution, MDC 14, MDC 15

Recommendations: Compare member-specific information to the list of members identified for the Care Management program to ensure appropriate members are identified.
Outcome: Member-specific information for the Iowa Medicaid members who were included in the numerator for this analysis were forwarded to the Medical Services Care Management Team. 43 members were not included in the members identified for Care Management. The Care Management parameters were reviewed and it was determined that the members became eligible after the initial list was developed.
Actions: The member-specific information was provided to the Medical Service's Care Management team. The members were contacted telephonically for enrollment into the program.

Follow-up: The Care Management enrollment process will be enhanced to run reports every 6 months.

Selected Performance Indicator PQI-2 Perforated Appendix Admission Rate

Rationale for PQI selection:

Numerator: Discharges with ICD-9-CM diagnosis code for perforations or abscesses of appendix (see below) in any field among cases meeting the inclusion rules for the denominator. Include 5400, 5401.

Denominator: All non-maternal discharges of age 18 years and older in Metro Area or county with diagnosis code for appendicitis in any field. Include 5400, 5401, 5409, 541.

Population/Demographics	
☒ Age	Younger population comprises most of the cases; 39% of the cases are individuals under the age of 30; further 70% of the cases are made up of individuals under 40
☒ Gender	The gender description is relatively equal with Women being slightly more likely to have this condition
☒ County of Residence	
Program Variables	
☒ Coverage Group	
☒ Aid Type	
☐ Service Area	
☐ Waiver Type	
Provider Data	
☐ Provider Type	
☒ Provider Name	There really is no discernable pattern or trend in aid and coverage type, nor is there any significant variances in any geographic area or provider
Claims Specific Data	
☒ Diagnosis Code/Description	5400, 5401 -
☐ Paid Date/Date of Visit	
☐ Claim Type (Inpt, Outpt, etc.)	
☐ Procedure Code/Description	
☒ Cost	
Exclusions	Transferring from another institution, MDC 14, MDC 15

Overview: The appendix drilldown doesn't really tell us much, there really is not an identifiable trend or disproportionate level of perforated appendices in a particular area or provider.

Actions: No further analysis is necessary for this indicator.

Selected Performance Indicator PQI-3 Diabetes Long-term Complications Admission Rate

Rationale for PI selection: Instead of simply looking at how many people had complications from short-term diabetes, the ratios take into account population growth. The ratios reflect what the raw numbers showed; specifically that there is a growing diabetes problem in the Iowa Medicaid population. Further analysis was needed to identify trends in the state by demographics, providers, or other factors.

Numerator: Discharges age 18 years and older with ICD-9-CM principal diagnosis code for long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified)

Denominator: Population in Metro Area or county, age 18 years and older.

Population/Demographics	
☒ Age	18 years or older - Older population with 83% of cases occurring in individuals over 40; highest prevalence is seen in ages 51-60
☒ Gender	Women are definitely more likely to experience this condition
☒ County of Residence	These counties had the largest increase in residents with long-term complications: Black Hawk; Dubuque; Polk; Pottawattamie
Program Variables	
☒ Coverage Group	
☒ Aid Type	The largest increases by aid type were in: Disabled Receives Mandatory State Supplementary Assistance(640); Iowa Care 200% group for people ages 19 to 64(60E); MEPD(60M)
☒ Service Area	
☐ Waiver Type	
Provider Data	
☐ Provider Type	These providers had the largest increases in number of patients with long-term complications: Allen Memorial Hospital (Waterloo); Genesis Health System (Davenport); Iowa Methodist Medical Center (Des Moines); Mercy Hospital Medical Center (Cedar Rapids)
☒ Provider Name	
Claims Specific Data	
☒ Diagnosis Code/Description	25040, 25041, 25042, 25043, 25050, 25051, 25052, 25053, 25060, 25061, 25082, 25063, 25070, 25071, 25072, 25073, 25080, 25081, 25082, 25083, 25090, 25091, 25092, 25093,
☐ Paid Date/Date of Visit	
☐ Claim Type (Inpt, Outpt, etc.)	
☒ Procedure Code/Description	
☐ Cost	
☒ Exclusions	Transferring from another institution, MDC 14, MDC 15

Recommendations: Compare member-specific information to the list of members identified for the Care Management program to ensure appropriate members are identified.

Outcome:

The member-specific information was provided to the Medical Service's Care Management team. The members were contacted telephonically for enrollment into the program.

Follow-up: The Care Management enrollment process will be enhanced to run reports every 6 months.

Selected Performance Indicator PQI-14 Uncontrolled Diabetes Admission Rate

Rationale for PI selection: Instead of simply looking at how many people had complications from short-term diabetes, the ratios take into account population growth. The ratios reflect what the raw numbers showed; specifically that there is a growing diabetes problem in the Iowa Medicaid population. Further analysis was needed to identify trends in the state by demographics, providers, or other factors.

Numerator: All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication.

Denominator: Population in Metro Area or county, age 18 years and older.

Population/Demographics	
☒ Age	The majority of recipients are between the ages of 41-50 (32%); further 61% of all the cases are from recipients ages 41-60
☒ Gender	Based on data from the last three years it would seem that women are almost twice as likely as men to incur uncontrolled diabetes complications
☒ County of Residence	
Program Variables	
☒ Coverage Group	
☒ Aid Type	Half of all recipients receive a particular aid type: *Disabled Receives Mandatory State Supplementary Assistance(640);* combining this group with the *FMAP (308)* aid type accounts for more than 70% of all the cases
☒ Service Area	
☐ Waiver Type	
Provider Data	
☐ Provider Type	
☒ Provider Name	Genesis Health System in Davenport saw a substantial increase in cases last year (rising from 1 to 10); likewise Scott county had the same increase which would suggest that the Davenport area has a disproportionate number of uncontrolled diabetes cases
Claims Specific Data	
☒ Diagnosis Code/Description	25002, 25003
☐ Paid Date/Date of Visit	
☐ Claim Type (Inpt, Outpt, etc.)	

☒ Procedure Code/Description	
☐ Cost	
☒ Exclusions	Transferring from another institution, MDC 14, MDC 15

Overview: Member-specific information for the Iowa Medicaid members who were included in the numerator for this analysis was forwarded to the Medical Services Care Management Team. If the members were not currently enrolled in Care Management, the members were contacted to become involved. Type 2 diabetes (adult onset) has seen the most significant growth and accounts for 80% of the uncontrolled diabetes cases
Actions: Continue to monitor quarterly
Recommendations: Review in 6 months
Outcome: Continue to monitor

The MVM team will continue to review and monitor the results of the PQI data on a quarterly basis. There is a lag time of six months to allow for claims submission. All PQI reports include the names of the Medicaid members making up the PQI selection. The Medical Services care management program staff contacts these members and offer care management services. The focus for care management outreach is on the following PQIs:

- Diabetes
- Asthma
- Congestive Heart Failure
- Chronic Pulmonary Disease

Claim Review Analysis

The MVM team reviews claims data as a tool to identify opportunities to enhance the management of Medicaid expenditures. Claim studies are generated quarterly and display claims by major diagnostic codes (MDC) for FY 2002-2007 and include procedure amounts and percent of change from 2002 to 2007. Claims are also reviewed by MDC by claim type. Additional claim drill downs are available for the team's review as needed. To assist with analysis the team considers the following data:

- Total cost and number of claims/units by fiscal year
- Major diagnostic category (MDC)
- Claim type by MDC
- Demographics including gender, age and county of residence
- Claim type by provider

Claims review study initiated in SFY 2008 and continuing in SFY 2009 was the trending expenditures for MRI and CT scans. The following checklist summarizes status of this project.

MRI/CT Utilization Project

Utilization of MRI/CT

Rationale for selection: Based on preliminary data extractions a high utilization of MRI/CT was identified, therefore further analysis is warranted to identify the need for continued observation by medical review.

Numerator: All Medicaid members who had a MRI/CT paid for in FY'07 in a non-emergent setting.

Denominator: All eligible Medicaid members.

☒ Population/Demographics	
☒ Age	0 and older
☒ Gender	Male and Female
☒ County of Residence	All counties
☒ Program Variables	
☒ Coverage Group	All eligible Medicaid Members
☒ Aid Type	No restrictions
☐ Service Area	N/A
☐ Waiver Type	N/A
☒ Provider Data	
☒ Provider Type	Outpatient settings and providers that file under a HCFA 1500
☒ Provider Name	Top providers have not been identified yet
☒ Claims Specific Data	
☒ Diagnosis Code/Description	Top ten have not been identified yet
☐ Paid Date/Date of Visit	All data are from claims paid in FY'07
☐ Claim Type (Inpt, Outpt, etc.)	Outpatient and HCFA 1500
☐ Procedure Code/Description	306, 70336, 70552, 70553, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72196, 73220, 73221, 73720, 73721, 76093, 76094, 77058, 77059, 77012, 77014, 77011, 77078, 76071, 307, 76070, 76380, 76375
☐ Cost	
☒ Exclusions	Inpatient and Emergency Room

Overview: Initial data pull has yielded more questions regarding the type of data that was pulled. Have begun to look at the utilization of the top procedure codes in relation to the top diagnosis codes to ascertain whether oversight of these procedures through medical review would be warranted.
Actions: Continue to drill down claims data to determine utilization by diagnostic groups.
Recommendations: Continue study
Outcome: N/A – project is ongoing

Claims review will continue with data refreshed every three months. A minimum of three claims review projects, either new or continuing, will be managed by the MVM team.

Healthcare Effectiveness Data and Information Set (HEDIS)

In addition to HCUP data and claim review results, the MVM team uses the HEDIS data for comparing Iowa Medicaid performance from one year to the next, and to that of other states and/or commercial populations. For the outcome assessment for SFY2007, the following outcomes were evaluated and are available to the MVM to consider:

- Well child visits in the first 15 months of life
- Well child visits in the third, fourth, fifth and sixth years of life
- Annual dental visit
- Children and adolescents' access to primary care practitioners
- Use of appropriate medications for people with asthma
- Adults' access to preventive/ambulatory health services
- Prenatal and postpartum care
- Comprehensive diabetes care: Hemoglobin A1c testing

The results of the HEDIS data were used to inform the diabetes and asthma care managers regarding how they may need to intensify educational interventions.

Summary

All of the projects discussed in this report were developed with regard to long-term sustainability, potential impact on health outcomes and potential impact on costs. Iowa Medicaid data for selected projects will be periodically compared to industry standards and quality benchmark data. Comparison results outside an expected range (exceptions) will provide indications of target areas for further investigation and potential improvement. MVM priority activities for SYF 2009 include:

- Quarterly review and follow up of PQI results
- Analysis of claims with missing or unknown diagnostic information to promote transparency for Medicaid expenditure.
- Analysis of incidents of low birth weight and maternal healthcare with a goal of improving outcomes

Attachment 3

IOWA
CHRONIC CARE
CONSORTIUM

EXECUTIVE SUMMARY

Study Validates Use of Technology-Based Remote Monitoring Platform to Reduce Healthcare Utilization and Cost

Results from the Iowa Medicaid Congestive Heart Failure Population Disease Management Demonstration confirm that a population and technology based remote monitoring platform can greatly reduce the need for costly acute care services by involving patients in their care, improving care efficiencies and promoting healthy behaviors.

The demonstration included 266 Iowa Medicaid members and was conducted by Iowa Medicaid Enterprises (IME); the Iowa Chronic Care Consortium (ICCC), an Iowa based voluntary collaboration of public, private, academic and government organizations; and Pharos Innovations, a partner in the next generation of healthcare financial performance improvement through a device-free remote monitoring platform. It was launched to provide Iowa Medicaid with a cost-efficient, high quality, self-management support and care coordination program for its members with heart failure.

Results

Third-party validated results, compared to baseline, include:

- **66% enrollment after one year** for the extremely difficult to reach and retain Medicaid population
- **72% of Medicaid particpants reported the program helpful** to being in better communication with their physician
- **24% reduction in hospital admissions** – Compared to 22% *increase* for the matched cohort
- **22% total bed days decrease** – Compared to 33% *increase* for the matched cohort
- **Nearly $3 million savings** from reduced healthcare service utilization – Compared to $2 million *increase* for the matched cohort

Implications

Due to the demonstration's success, Iowa Medicaid has committed to expanding the length and reach of the program. This heart failure program met Iowa Medicaid's objectives of improving the medical stability of chronically ill members, increasing the number of members with medical homes, reducing avoidable health care costs to the Iowa Medicaid program, and providing a program that was well received by participants.

Iowa Medicaid Congestive Heart Failure Population Disease Management Demonstration

Evaluation Report

The Iowa Chronic Care Consortium (ICCC) in collaboration with the Iowa Medicaid Enterprise (IME) launched the Iowa Medicaid Congestive Heart Failure Population Disease Management Demonstration Project to improve the accessibility, capability, quality and efficacy of care to the target population through a collaborative and community-based self-management and care intervention plan. The project began with a patient engagement "go live" date of October, 2006. The intervention portion of the program ran through October, 2007.

Background

The Iowa Chronic Care Consortium (ICCC) was organized in 2001 to advance discussion in Iowa of new and innovative strategies that would address the care of Iowans with chronic disease. Iowa is a rural state with an aging population that has 60 of its 99 counties designated in whole or in part as health provider shortage areas (HPSAs). Iowans in remote parts of the state have limited access to timely intervention for chronic disease. During 2002, ICCC conducted a research review of chronic disease management models for effective deployment in Iowa. While ICCC focused interest on models applicable to several chronic diseases, its specific interest was on models that would serve individuals with congestive heart failure (CHF) and diabetes.

In 2003-05, ICCC partnered with a large Iowa-based health system to implement a case-managed telehealth demonstration project to improve the lives of patients with CHF. Over 350 patients participated in the year-long pilot and evaluation of the program revealed improvement in patient functionality, reduced hospital and ER visits and high participant satisfaction. Through a cost-avoidance analysis, it was estimated that the program saved providers, health plans, and consumers over $1 million.

With this successful pilot as a model, ICCC approached the Iowa Medicaid Enterprise to implement a similar intervention program, using a population-based approach, for members of Iowa Medicaid. The strategy was to engage up to 250 members who have CHF, and after a year, compare their health status with a similar group that did not participate in the program. The goal of the program was to reduce the cost burden to Iowa Medicaid through reduced hospitalizations and readmissions, and to improve the quality of life for their members by promoting improved self-management support.

Disease Burden

Congestive heart failure is a progressive chronic condition with mortality rates averaging 20% within one year of diagnosis and 50% within 5 years. For persons with a more advanced disease state, one year mortality is as high as 40% (*Cardiovascular Roundtable, 2000*). Hospitalization for CHF carries a significant economic burden and is an important determinant of successful clinical and patient self-management. In the 1999 Agency for Health Care Policy and Research (AHCPR) Publication No. 99-0046, congestive heart failure was listed as the fourth most common reason for hospital admissions. In 2003 hospitalization charges in Iowa for CHF totaled $79,030,349 (*Iowa Hospital Association 2003 In-Patient Discharge Data*). Eighty-six percent of the payments were covered through Medicare, 4% through Medicaid, and 10% through private payers. This represents inpatient hospitalizations only, and does not consider ER visits, outpatient services or physician visits.

National readmission rates for patients with CHF are high, averaging 21-25% at 30 days and nearly 50% at 6 months (*Cardiovascular Roundtable, 2000*). According to the Cardiovascular Roundtable, these hospital admissions are frequently avoidable. Factors contributing to preventable hospitalizations include noncompliance with medications, poor social support, inadequate hospital discharge instructions, inadequate follow-up, failure to receive or seek medical intervention, and side effects of medications.

Project Objectives

Six specific objectives were targeted for accomplishment through the demonstration project. These objectives are outlined in the project plan document as:

- To facilitate improvement in the medical stability of Iowa Medicaid members with CHF through reduced hospitalizations and ER visits
- To contribute to the containment of total medical costs for Iowa Medicaid members with CHF
- To improve overall access to care for Iowa Medicaid members with CHF by establishing medical homes for all participants
- To improve quality of life and care outcomes for Iowa Medicaid members with CHF through utilization of real time data
- To improve self-management for Iowa Medicaid members with CHF through care management and care coordination
- To ensure sustainability of this model of care for Iowa Medicaid members with CHF by finding alternate reimbursement solutions beyond grant funding.

Program Components

The Population

Participation criteria for the program was agreed upon prior to program initiation. IME required that there be equal opportunity statewide to participate. Available funds allowed the ICCC to enroll up to 250 members into the program. Anticipating that this population may be more challenging to engage than in a commercial population, the pool of eligible candidates needed to be at least 1,000 members. Eligible candidates were identified through Iowa Medicaid medical claims data. A detailed data request was developed and carefully documented to describe the eligible population. As a primary requirement, all candidates were identified through either a primary or secondary diagnosis of congestive heart failure. However, as the population was further filtered, there were not enough members that fit the "ideal" category of at least one hospital readmission within a 6 month period. So, three "risk pools" were identified, with enrollment efforts beginning with the highest risk category. The enrollment phase of the program began in October of 2006 and was capped at 266 members in April 2007. All but 20 participants were enrolled from the top two risk pools. All members received a minimum of six months participation.

This program was voluntary. All eligible members received a letter of invitation, followed by a phone call from a call center. If the member agreed to participate, they were able to access or "activate" into the program within a few days of acceptance. They were free to withdraw from the program at any time. Participants were disenrolled based on the following criteria:

1. Patient choice
2. Transfer to hospice
3. Transfer to a skilled nursing facility (long term)
4. Death

Of the members who were disenrolled, 62 chose to do so before receiving the "minimal intervention" (5 daily call-ins) and were not included within the intervention pool for evaluation purposes. Two hundred and four charts were included in the final evaluation. When ICCC grant funding for the program ended in October 2007, 198 members were active.

Age Demographics:

Through analysis of satisfaction surveys, (123 out of a possible 236 were returned) the age groups of the participants were as follows:

31-40 years old: 0.5%

41-50 years old: 13%

51-60 years old: 24.3%

Older than 60: 60.5%

The Intervention

The primary purpose of this program, named the Iowa Medicaid Heart Wise Tel-Assurance® Program, was to improve quality of life for participants and reduce avoidable health care utilization. The key intervention was daily self-monitoring of weight and symptoms that signaled early warning signs of worsening heart failure. The self-monitoring process was accomplished through the use of a low-cost, ubiquitous telephone linked to the Internet and software that is disease specific and provided gathered data to Iowa Medicaid nurse care coordinators. The system was deployed and developed in conjunction with Pharos Innovations®. Tel-Assurance® is a telephone-based system that collects and aggregates data then provides reports online and in real time. This system employs Interactive Voice Response (IVR) technology and is easily implemented.

Once the patient agreed to participate in the program, they were educated on how to call a toll-free number each day and report any clinical symptoms that they may have experienced within the past 24 hours. They simply choose either "yes =1" or "no=2" on their touch tone phone to reply to a pre-recorded list of seven questions. They were required to complete a daily weight before the call. (The program provided a scale for home use for participants who did not have one.) The Tel-Assurance® system captured this information in an electronic database which was monitored on a real-time basis by IME care coordinators. The care coordinators provided the following services when detecting "variances" from normal self-reports: education to promote self-management support; referral to providers for early warning signs of heart failure exacerbation; collaboration and care coordination with support services such as home health; and routine reporting and feedback to providers as requested. While the care coordinators focused on CHF symptoms, they were often asked to assist members with other health concerns. People who suffer from heart failure often have multiple chronic conditions, such as hypertension, diabetes and depression. Any one of these conditions can influence their overall health.

Program design recognized that rural (or urban) residents who are ill with limited mobility should not be disadvantaged in gaining access to needed medical services. Telephonic support allowed them to participate on a daily basis and for care coordinators to contact them whenever they experienced concerns or symptoms. This program was HIPAA compliant and required informed consent by the patient prior to participation.

Another important program design component was the utilization of current resources and expanded access by trained nurses. The IME care coordinators for the Heart Wise Tel-Assurance® Program were part of existing staff, and no additional staff was hired. Because of the IVR system, the staff was utilized in a very efficient and targeted manner. On any given day, they interacted with about 15-20% of the participants.

Depression has been recognized as a common and debilitating co-morbid condition to people with heart failure. For this project, the IVR system automatically screened every participant for depression, using the Patient Health Questionnaire-2 (PHQ-2) survey. Participants found to be at risk were then asked additional questions through the Patient Health Questionnaire-9 (PHQ-9) and triaged to follow-up care and referral as needed.

Finally, the combination of self-management support and care coordination was designed to reflect disease management components as defined by the Disease Management Association of America (DMAA). With the

exception of the depression assessments and follow-up, the one element (as recommended by DMAA) that was not implemented was the use of evidence-based guidelines. Although providers may have prescribed treatment following evidence-based guidelines, there were no set protocols for which to assure that the guidelines were followed.

There was significant administrative and clinical program support during the 12-month intervention timeframe. Each month, ICCC hosted a clinical team conference call with participation from ICCC, IME and Pharos Innovations. Pharos generated a monthly "dashboard" which included program data, such as the number of variances, (both "no call-in" and "clinical" variances), and the number of active, inactive and disenrolled participants, as well as the reasons for disenrollment. During the call, the care coordinators could also discuss questions, issues and challenges that they were experiencing in supporting the participants. This real-time learning provided tremendous value in perfecting the program and making program improvements along the way.

Program Evaluation

As an integral component of the program's planning and implementation, a comprehensive evaluation plan was developed by the project steering committee and certified through the Disease Management Purchasing Consortium. The plan was built around the Clinical Value Compass, a well-recognized evaluation tool developed by the Hitchcock Clinic. The Clinical Value Compass requires outcomes measurement in the areas of patient functionality, clinical outcomes, resource utilization (cost) and patient satisfaction. The evaluation was completed through the combined use of both primary data collection (i.e., gathering data from participants through questionnaire), and an independent analysis of secondary data from Medicaid claims data. Participant engagement (captured as no-call reports) and clinical intervention opportunities (captured as "clinical variances") were reported monthly by the vendor.

Evaluation measures for the project included:

Clinical Value Compass Measures And Evaluation Tools	
Satisfaction	Questionnaire (12 months.)
Clinical Improvement	Inpatient, Emergency Room episodes
Patient Functionality	Minnesota Living with Heart Failure Questionnaire (Baseline and program completion)
Cost	Medical claims data of Inpatient, ER, medications, physician office visits

Evaluation Methodology

Satisfaction survey questionnaires were developed using a 5-point Likert scale with 1 indicating strong disagreement and 5 indicating strong agreement. The questionnaires were sent out to all active participants, and to those who were disenrolled from the program. In an effort to gather feedback from those who were disenrolled, a targeted effort, using phone call follow-up, was made to all participants who were disenrolled.

Clinical improvement was measured by extracting data from medical claims for inpatient hospitalizations (for CHF as well as all-cause), total bed days, and ER visits. This was reported in terms of visits.

Patient functionality was measured on initial admission and at the end of the program, using the standardized tool Minnesota Living with Heart Failure Questionnaire (MLWHF).

Cost of care and financial impact was measured by extracting medical claims data for inpatient hospitalizations (for CHF as well as all-cause), ER visits, medication use (for all reasons) and physician office visits. This was reported as a dollar value based on data provided by IME.

Baseline Data and Matched Cohort Design

Retrospective claims data covering one year prior to intervention (i.e., October 2005 thru October 2006), were extracted to be used as baseline data. Two hundred and five enrollees were selected into the baseline evaluation database – 70 of which were male and 135 female. Eighteen of the initial participants were lost to observation prior to six months into the evaluation period.

The baseline data were compared to data that were captured during the following year over which the disease management project was taking place. The project planners were aware of the fact that such comparison that is based solely on the participating population will not be adequate for the required evaluation. Therefore a plan was developed to identify a "matching cohort" of CHF patients as an additional method of a control group for the evaluation. Matching was achieved through the use of a "propensity scoring" method. Table 1 shows how the participants and the matched cohort compared on the variables that were used for matching. There are no statistically significant differences in the averages that are reported on Table 1, for individuals in the program and the matched cohort.

Table 1: Variables Used to Perform Propensity Score Matching and the Averages at Baseline

Variables	Cases (N=187)	Matched Cohort (N=187)
Gender (Percent males)	35.3%	33.3%
Percent with COPD	18.7%	15.1%
Percent with hypertension	59.4%	59.7%
Percent with diabetes	56.2%	57.0%
Percent with depression	23.5%	21.5%
Mean age	66.3	66.32
Mean inpatient admissions	0.55	0.60
Mean bed days	2.67	3.17
Mean HF related admissions	0.13	0.15
Mean HF bed days	0.59	0.84
Mean doctor visit	15.53	15.85
Mean ER visit	4.02	4.40
Mean ER visit for HF	0.57	0.72
Mean cost of drugs	$2,752.14	$3,027.49
Mean doctor office charges	$2,376.55	$2,732.86
Mean inpatient charges	$100,644.86	$143,371.85
Mean medical utilization charges	$105,773.55	$149,132.20

Findings

Patient Satisfaction

At the completion of the program (October 2007), a brief patient satisfaction survey was mailed to all active and disenrolled participants. Knowing that disenrolled participants may be less likely to return the survey, additional effort was made to encourage them to complete the survey. Of the eligible 236 participants, a total of 123 surveys were returned from active participants, and 6 surveys were returned from disenrolled participants. Results from the surveys indicated that the majority of participants were satisfied with the program.

Results are as follows:

Survey Question:	**Participant Responses**
Q.1 Overall, how satisfied are you with the Heart Wise Tel-Assurance® program?	63% were highly satisfied or very satisfied
Q.2 How confident are you that you can self-manage your heart failure symptoms and correctly take your medications?	73% were very confident or mostly confident

Q.3 How has your confidence level changed from before you began the program?	60% reported some improvement up to greatly improved.
Q.4 How valuable were the daily phone call-ins to you?	52% felt that the daily phone calls were of great or high value
Q. 6 How likely would you be to recommend the Heart Wise Tel-Assurance® program to others?	83.7% would recommend the program to others

Medical Home

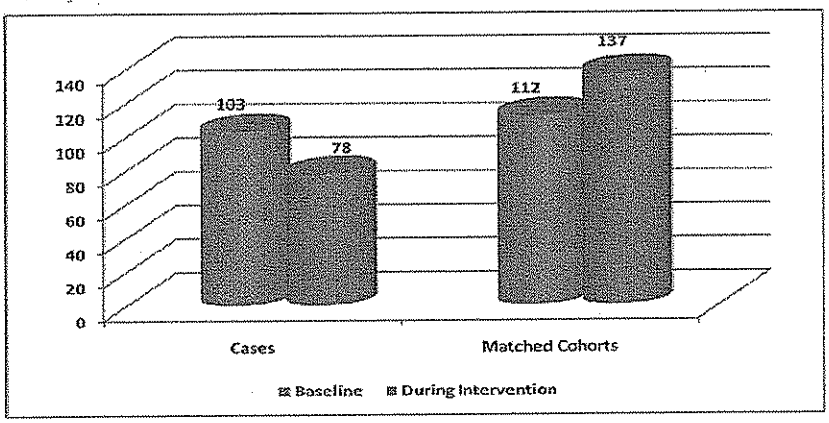
One of the key objectives for this program was to improve access to care for Iowa Medicaid members with CHF. This was measured through the number of members who reported that they had a medical home--defined for this project as a "regular provider." Before enrolling in the Heart Wise Tel-Assurance® program, 77.8% of members indicated that they used a regular provider. Of the initial 17.1% who had indicated that they did not have a regular provider, at the conclusion of the program 76% acknowledged that they now have a healthcare provider they consider their regular provider.

Participants were also asked about the value of the program in helping them to be in better communication with their provider. At the conclusion 71.5 % noted that the program was of moderate to great value in providing this support.

Clinical Improvement

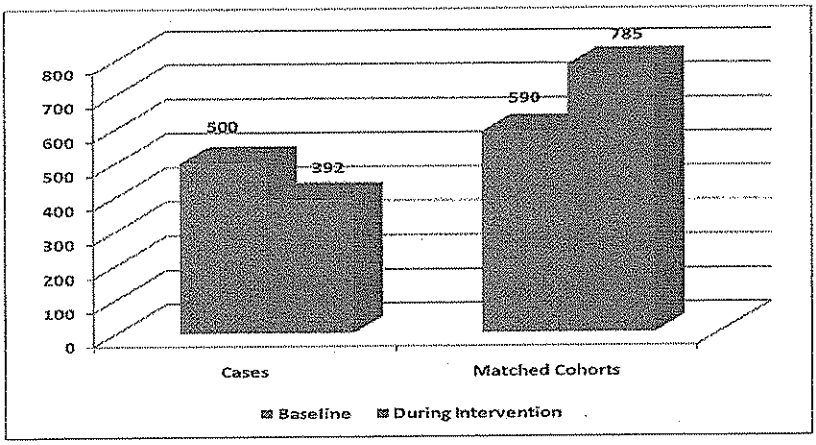
There were a number of noticeable changes that differentiated the participants from the individuals in the matched cohort that can be observed in the data that were gathered during the project period. Figure 1 depicts the changes in terms of inpatient admissions. The number of inpatient admissions of participating individuals declined over the two years, while among the non-participating cohort it increased dramatically. Although the differences in the number of admissions were only significant at $p < 0.10$, this is considered a substantively significant difference nevertheless.

Figure 1: Comparison of Inpatient Admissions between Participants and Matched Cohort before and During Program Participation



The difference between the cases and matched cohort during the program implementation year is even more dramatic in terms of total bed days (see Figure 2). Hence, not only were participants less likely to be admitted for inpatient care, but when they were, they spent less days hospitalized. This difference is statistically significant ($df=186$, $p < 0.05$).

Figure 2: Total Bed-Days



Patient Functionality (Quality of Life Assessment)

For this project, the Minnesota Living with Heart Failure survey was chosen as a measurement of patient functionality. The survey is standardized and well recognized as a quality of life assessment for this population.

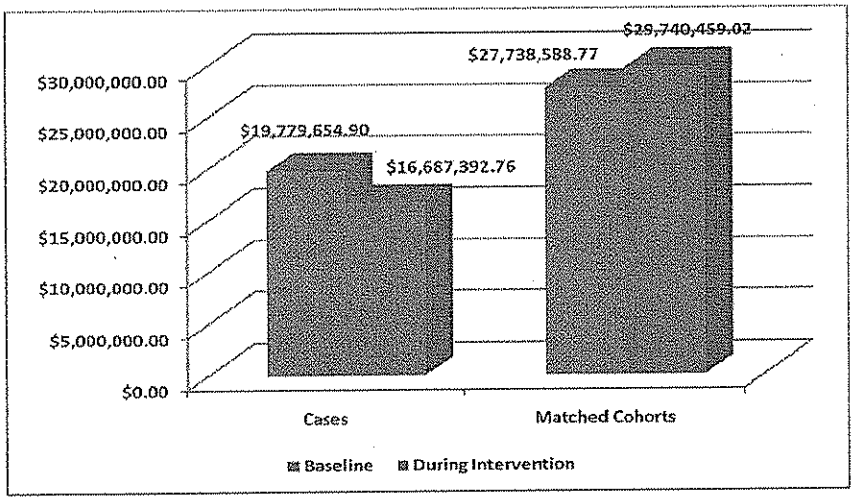
This survey asks 21 questions that allow the participant to rate the impact of a symptom or activity on their daily lives. Questions include physical symptoms, energy levels, depression and sexual function. They rate the impact on a scale of 1-5, with 1 being minimal impact and 5 being considerable impact.

The survey was administered both at baseline and at the completion of the program. There were 87 baseline surveys returned and 116 surveys returned at the completion of the program. These surveys were sent to all active participants as well as those who were disenrolled from the program. There were methodological challenges in the administration and follow-up of the surveys that prevent drawing conclusions. However, one observation can be made. Participant answers to all questions, both at baseline and post-program revealed low mean scores (as a group). In other words, their chronic condition did not appear to greatly affect their lives in a negative way. As congestive heart failure is a progressive disease, participant quality of life did not appear to deteriorate (they did not perceive their health as "worse") over the year. The tool was not administered to the matched cohort. Therefore, it is not known whether their quality of life may have changed over the course of the year of intervention for that group.

Cost of Care and Financial Implications

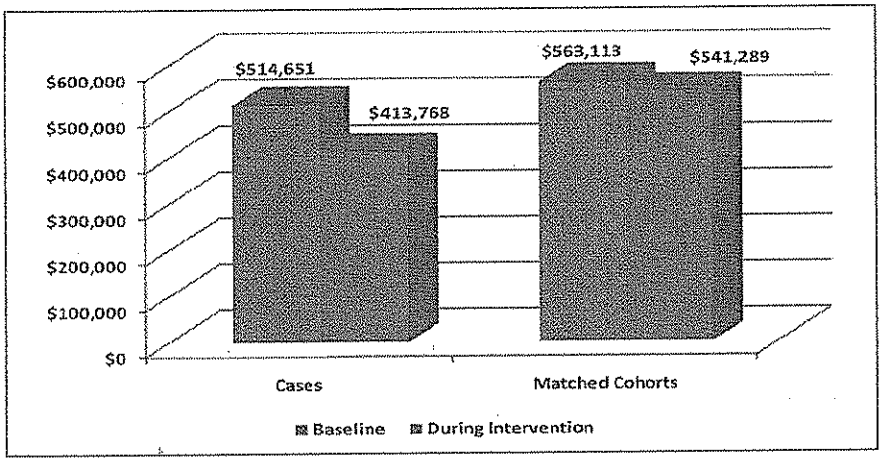
As noted in Figure 3 below, the participating CHF patients incurred less cost to Medicaid over the period of participation. In contrast, the cost incurred by non-participating CHF patients increased over the same period.

Figure 3: Total Charges for Medical Care Utilization



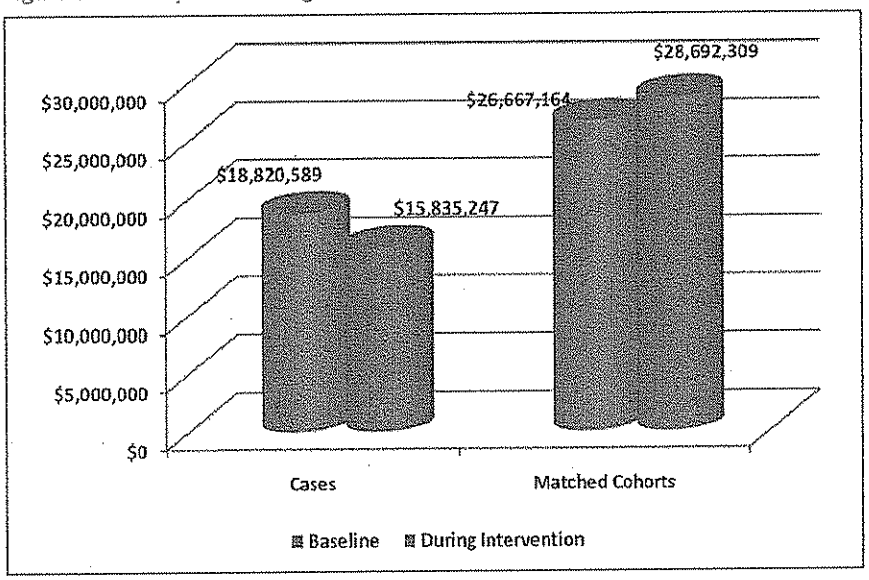
The overall cost savings that is observed in Figure 3 above is due to significant reductions in charges for hospital stays and total pharmaceutical charges (see Figure 4 and Figure 5).

Figure 4: Total Cost of Pharmaceuticals



Since the cost of pharmaceuticals for each group was at a statistically identical level during the baseline period (prior year to the program), one can therefore infer that the reduction in these averages among the participating individuals is the outcome of program participation.

Figure 5: Total Inpatient Charges



Heart failure-related inpatient charges and bed days also improved, though not to a level that was statistically significant. This is most likely due to the low total number of participants that needed inpatient care. Other outcome variables whose levels did change in the desired direction between the baseline and the intervention year included doctor visits and ER visits. The positive trend in these variables contributed to the overall reduction in healthcare expenses.

Depression Screening

Depression represents a significant co-morbid condition for person with heart failure. Based on this finding from previous ICCC demonstration projects, all participants in the Heart Wise Tel-Assurance® Program were routinely screened for depression. A PHQ-2 was administered via the Pharos IVR system at baseline and quarterly thereafter. The PHQ-2 is the depression questionnaire with the largest body of validation and clinical experience. If a participant scored "at risk" on the PHQ-2, a PHQ-9 was administered. In partnership with the Iowa Medicaid mental health provider, a protocol was developed for follow-up and referral. Risk levels were categorized as low, moderate and high. Members at moderate risk were followed by the care coordinators, and members at high risk were referred to the mental health provider for additional follow up. Of the 267 unique members screened, 47% were low risk, 40% were moderate risk and 23% were high risk and referred for further assistance.

Discussion

The value of this demonstration project is, in part, the efficient and effective use of clinical support staff to meet the needs of high risk Iowa Medicaid members who are unfamiliar with or unable to navigate the complex medical health care system. Through the use of Tel-Assurance®, the staff was able to monitor and proactively intervene with members who might otherwise have needed immediate or regular admittance to either the ER or hospital. In addition, through educational support, members were assisted in how to better self-manage their co-morbid health conditions. This is evidenced through the reduction in all-cause inpatient hospitalization, use of medications, and total medical costs.

There were some project assumptions that were both anticipated and addressed within this demonstration. They included:

Participant Adherence: It was anticipated that this population may be less adherent in self-reporting on a daily basis. The average "no-call" variance for a commercial population (and in a previous ICCC demonstration project) is approximately 10% each day. For the first several months of this project, the no-call variance was between 20%-30%. The care coordinators spent additional time contacting and communicating with patients, which greatly increased their workload. To address this issue, non-professional call center staff members were utilized to contact "no-call" patients and educate them on the importance of calling in on a regular basis. As the enrollment phase was completed and all participants were on "maintenance," the no-call variance stabilized at 20%, which continued to be above average to that of commercial populations.

Participant Compliance: Persons with congestive heart failure often have to take a multitude of medications, watch their lifestyle more closely and deal with other chronic conditions. In addition, depression may impact their compliance. In the Medicaid population, there are other socio-economic factors that could negatively influence

compliance. The "clinical variance" rate, as monitored through Tel-Assurance® is one way to assess for non-compliance. One of the chief causes for a clinical variance is weight gain. This is commonly due to either nutrition habits or medication management. The clinical variance rate for this population settled at about 15%, which is also higher than the commercial average. There were many anecdotal stories of the importance and benefit of contacting patients to address the variance, but this practice had a clear increase on the overall staff workload. However, by October of 2007 the clinical staff was far more confident in managing the variances, and they were reporting greatly decreased workloads for this project.

Disenrollment: It was anticipated that disenrollment would be high, partly because of members transitioning in and out of the Medicaid program, and because overall trends show that this population has difficulty remaining engaged in longer-term programs. Of the initial 300 members who agreed to participate in the program, 62 were disenrolled within the first week. By the end of the program, a total of 100 participants were disenrolled. Reasons varied and were documented. The disenrollment percentage of 30% is comparable to the normal expectation in community-based intervention programs.

Participant Pool: In previous projects, participants have been eligible for the program based on frequent hospitalizations and re-hospitalizations. This participant pool was different in two ways. The participants were generally younger in age (the previous projects included mostly participants on Medicare), and they were not frequently hospitalized. In fact, some had not been hospitalized for CHF within the previous year. As there was such a significant difference in overall healthcare costs between the intervention group and the matched cohort, it may be of value to consider the use of this intervention for "prevention" of exacerbations as well as "intervention" for those who required frequent medical care.

Limitations

As in any intervention of this kind, there were some limitations to this demonstration program.

Enrollment Challenges: Of the 1,980 letters of invitation that were sent to eligible participants, only 598 had documented telephone numbers. Without phones, the intervention could not be effective. In addition, there were a high number of inaccurate phone numbers listed within the Medicaid database. This caused some delay as well as extra cost for researching correct phone numbers. On the positive side, of the 598 who were able to be contacted, 300 agreed to participate. This "capture" rate was much higher than anticipated. During the program, five members (who had lost local phone service) were provided with telephones in order to allow them to keep participating in the program.

Use of Evidence-based Guidelines: For this demonstration, the "medical intervention" was limited to the care that was provided by the IME care coordinators. There was no infrastructure to provide additional outreach to

Iowa Medicaid providers to encourage medical treatment based on best practice guidelines for heart failure. For example, because of the "scatter" of providers across the state, there was no one medical director who could prescribe a protocol of diuretic therapy that the care coordinators could use in the event of weight gain. There was no encouragement to utilize the health care system in the most efficient means. As another example, the care coordinators related that despite their encouragement of patients to see their personal provider for medical care, the personal provider sometimes directed their patients to the ER, as opposed to being seen in their medical clinic.

Staff Workflow: Within months of the launch of this program, the IME care coordinators also became responsible for initiating a care coordination program for members with diabetes. While they continued to address the variances of the CHF patients, their attention was primarily on "reacting" to variances for CHF. There was no "general" education program for participants, so not all members received the same coaching or education. It is recommended that, with future programming, all members receive some level of health education, individualized health coaching and follow up.

Continued Evaluation: Finally, as positive as the outcomes appear at the end of one year of intervention, ICCC recognizes the limitations of an evaluation that is performed only at this point. Especially in a population with chronic disease it is important to continue to trend the health status of these individuals over time. IME has committed to continuing the program through their waiver program, and it is highly recommended that another evaluation of both the intervention and cohort groups be conducted by February 2009, or one year after this project's final evaluation.

Recommendations

The following additions are recommended for improving the value of the Heart Wise Tel-Assurance® program for the current and future participants.

- Tighten the program through institution of medical treatment guidelines and evaluation of provider adherence
- Develop a general health education and coaching program that accompanies the Tel-Assurance® Program
- Code the Minnesota Living with Heart Failure Surveys in a way that baseline and follow-up surveys can be individually tracked
- Based on the program satisfaction ratings, the improvement in clinical quality as well as cost reduction, continue to offer the program for all Iowa Medicaid members
- Expand the model to additional chronic conditions
- Deploy this program to Medicare beneficiaries in the state of Iowa
- Replicate the program in other states that are affected by managed care (Iowa is largely a fee-for-service state, even within its Medicaid program)

Conclusion

The Iowa Medicaid Congestive Heart Failure Population Disease Management Demonstration project, through the development of the Heart Wise Tel-Assurance® Program, was launched to assist the Iowa Medicaid Program in providing a cost-efficient, high quality self-management support and care coordination program for their members with congestive heart failure. Its objectives were to improve the quality of care to members, increase the number of members who have medical homes, reduce cost to the Iowa Medicaid program and increase the number of disease management programs that are available for members with chronic conditions. All of these objectives were successfully met as evidenced by the evaluation.

The results of the program evaluation, as presented above, indicate that the intervention had a number of significant positive effects on the participants. A sizeable majority of the participants indicated that they were highly satisfied in what they obtained through their participation. The independent Medicaid claims pattern analysis also indicated that there was a substantial reduction in inpatient hospitalization among the participants over the first year of program participation. In contrast, the matched cohort of CHF patients who did not participate in the program had an increased level of inpatient care during the program period as compared to the previous year. The reduced level of inpatient care translated into a substantial savings in inpatient charges. Given that the cost of inpatient care constitutes a major portion of the cost to Medicaid, the savings in terms of the overall healthcare cost for the participants, as compared to the non-participating matched cohort, was also evident.

The Medicaid Heart Wise Tel-Assurance® Program impacted the lives of about 200 of its members. There was a significant financial benefit for Iowa Medicaid, even given the small size of the project. This group represented a younger and "less-ill" population than typical CHF patients, yet there was a significant risk index as noted from the high number of co-morbid conditions, and their high health care utilization at baseline. Most importantly, they responded positively to the daily monitoring, care coordination and self-management support. Therefore, over more time and with a larger participant pool, the impact would likely be more dramatic.

Acknowledgements

The Iowa Chronic Care Consortium (ICCC) is a voluntary collaboration of public, private, academic and government organizations whose purpose is to develop capacity for the state of Iowa to effectively manage the most prevalent chronic diseases affecting people in Iowa and to improve the health and productivity of individuals through access to patient centered proactive strategies for chronic condition management where they live and work.

The ICCC board includes members representing the founding organizations: Iowa Farm Bureau Federation; Mercy Health Network; Iowa Health System; Des Moines University; and the Iowa United Autoworkers.

ICCC would like to recognize that the success of this project and the positive impact on health and the quality of people's lives has been accomplished through the hard work and dedication of the IME care coordinators and social workers, the clinical leadership of the Iowa Medicaid Enterprise, and the expert guidance and support from Pharos Innovations. The University of Iowa Public Policy Center was instrumental in the development of the evaluation plan and their guidance is greatly appreciated. Finally, the public health faculty at Des Moines University provided final evaluation design and analysis that enabled this project evaluation to meet the rigorous evaluation criteria for quality as certified by the Disease Management Association of America.

Support for this demonstration project was provided in part by the State of Iowa, HRSA (through the Office for the Advancement of Telehealth grant number: 4 D1BTH05801-01-02) and the Iowa Chronic Care Consortium.

As ICCC continues its mission to improve the health of those with chronic conditions, it is actively committed to replicating this program and to deploying chronic care condition improvement strategies with additional populations.

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Outcomes of Care for Iowa Medicaid Managed Care Enrollees

State Fiscal Year 2007

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Outcomes of care for Iowa Medicaid managed care enrollees

Introduction

In June, 2007, the Commonwealth Fund released a report entitled, "Aiming Higher: Results from a State Scorecard on Health System Performance." The report ranked states' health care performance based upon four areas: access, quality, potentially avoidable use of hospitals and costs of care, and healthy lives. Iowa was ranked second overall and was the only state to rank in the top 25 percent on each of the four measures.[1]

Coupling the HEDIS measures and CAHPS survey results with the Commonwealth report outcomes provides additional information for determining how the state performs with regard to the health care system, in general, and the Medicaid program specifically. For the past five years the results of eight outcome measures encompassing children and adults, and preventive, chronic and acute care have been reported by the University of Iowa Public Policy Center (PPC). The PPC is the independent evaluator for the Medicaid managed care programs and assists the state in an effort to understand the process of care within the Medicaid program. Seven of the eight measures are recommended by the Centers for Medicare and Medicaid, while the eighth, annual dental visit, is used in recognition of the challenges found in providing dental care to Medicaid-enrolled children and adults.

For the outcome assessment for SFY2007, we evaluated the following outcomes:

- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth and sixth years of life
- Annual dental visit
- Children and adolescents' access to primary care practitioners
- Use of appropriate medications for people with asthma
- Adults' access to preventive/ambulatory health services
- Prenatal and postpartum care
- Comprehensive diabetes care: Hemoglobin A1c testing

This report will incorporate the results from the past five years on selected measures. In addition, we will include any special analyses that have been performed over time. For example, this year we were

[1] http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551

able to include foster children in the dental visit measure. As we look across the results for the past five years, it is important to remember that the Medicaid managed care programs have been changing. At the end of state fiscal year (SFY) 2004, John Deere, a Medicaid HMO, ceased the enrollment of Medicaid eligible individuals, as did Iowa Health Solutions during SFY 2005. Shifts in enrollment to Coventry HMO, MediPASS and the traditional Fee-for-Service (FFS) program may have affected the rates over time in ways that we are unable to quantify.

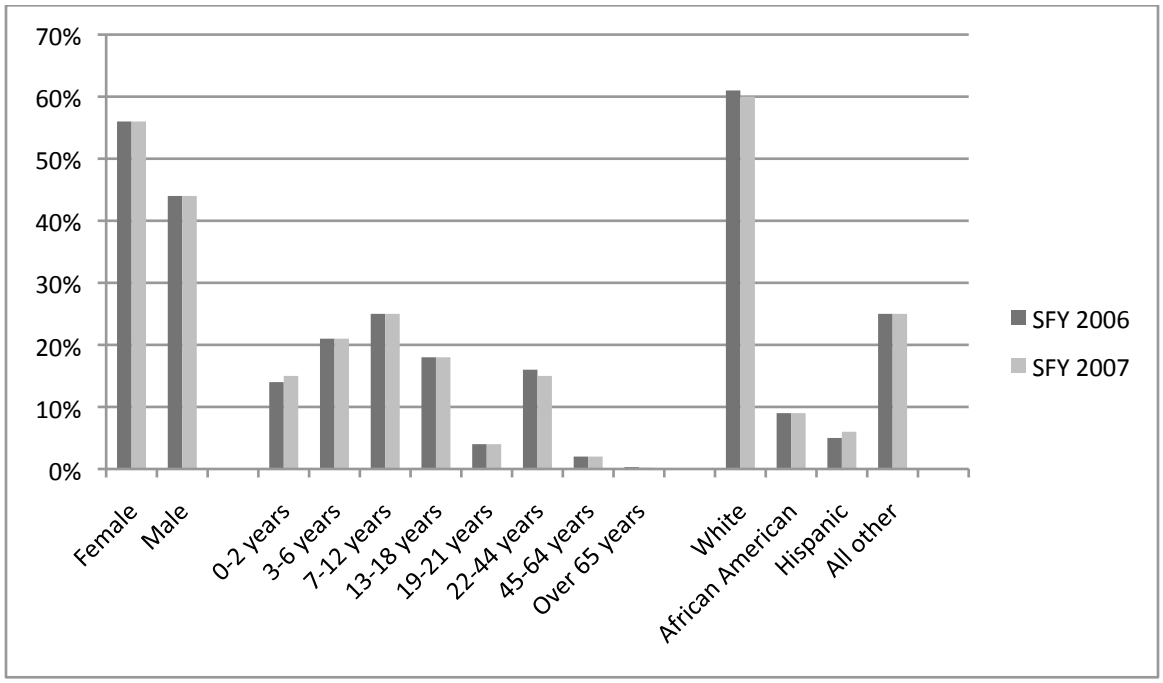
Despite the limitations of claims, encounter and enrollment data and the changes in the program over time, the results from the outcomes analyses provide a long-term view of specific measures within the Medicaid managed care programs. This long view allows us to determine whether the rates are remaining the same, decreasing or increasing, providing information that is critical to long-term program management and enrollee health.

Eligibility

The outcome measures evaluated in this report are computed for the population of Medicaid enrollees eligible for one of the managed care options, either MediPASS or Coventry HMO. Enrollees eligible for managed care are income eligible and live in a county containing one of these three options. Some counties do not have a managed care option available because providers will not participate in these programs. In addition, some counties may have a managed care option but it is not available to everyone within the county due to geographic constraints. In these cases, enrollees eligible for managed care are retained in the Fee for Service (FFS) option. Within our report, three groups, MediPASS, HMO, and FFS, are compared across the outcome measures. Enrollees are included in the measures in accordance with the protocols developed the National Committee on Quality Assurance (NCQA). The protocols vary by measure so that not all enrollees are included in all measures. Please see Appendix F for measure protocol specifications.

Figure 1 indicates the percent of enrollees by age, gender and race for SFY 2006 and SFY 2007 who were enrolled for at least 11 months in one of the three income-eligible programs. Of 303,398 enrollees who were income eligible during SFY 2007, 196,540 were eligible for at least 11 months. Because disclosing race is optional for Medicaid enrollees, it is difficult to determine the exact race distribution. The demographics of the Medicaid enrollees who are eligible for at least 11 months during the measurement year have remained unchanged from last year.

Figure 1 Comparisons of demographics for Medicaid enrollees who were eligible for at least 11 months in the measurement year, SFY 2006 and SFY 2007 in MediPASS, HMO or FFS



Outcome measures

Well-child visits in the first 15 months of life

Current recommendations from the American Academy of Pediatrics and the Iowa Department of Public Health Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedules recommend that children have at least 8 visits during the first 15 months of life[2]. A child following the schedule will experience well-child visits at 2-3 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months of age. These visits are to assess and address developmental issues, provide anticipatory guidance to parents, and determine the health of the child. Often the visits are used to provide needed immunizations for children, though immunizations are not required at all scheduled visits. For the HEDIS measures we indicate the proportion of children who turned 15 months of age during SFY 2007 and had 0 visits, 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, and 6 or more visits. To be included in the measure children had to be eligible for at least 14 of the first 15 months of life. Table 1 provides the rates for each of the three groups.

Table 1. Number and proportion of children receiving from zero to six or more well-child visits in the first 15 months of life, SFY 2007

		FFS	MediPASS	HMO	Total
0 visits	Number	192	720	23	964
	%	9.7%	11.0%	8.3%	10.6%
1 visit	Number	113	311	15	439
	%	5.0%	4.8%	5.4%	4.8%
2 visits	Number	142	378	18	538
	%	6.3%	5.8%	6.5%	5.9%
3 visits	Number	202	548	30	780
	%	8.9%	8.4%	10.8%	8.6%
4 visits	Number	311	841	39	1191
	%	13.7%	12.9%	14.1%	13.1%
5 visits	Number	436	1334	52	1822
	%	19.2%	20.4%	18.8%	20.0%
6 or more visits	Number	845	2410	100	3355
	%	37.2%	36.8%	36.1%	36.9%
Total	Number	2270	6542	277	9089
	%	100.0%	100.0%	100.0%	100.0%

[2] http://iowaepsdt.org/ScreeningResources/IowaScrRecs05.pdf

In an attempt to determine which well-child visits are most likely to be missed by Medicaid enrolled children, we calculated the proportion of children who obtained each visit within a one month window on either side of the suggested visit time. For example, a child born on July 1, 2006 would be expected to have a 1 month visit on August 1, 2006. If a well-child visit occurred between July 16, 2006 and August 14, 2006 we considered the child to have had a 1 month well-child visit. Figure 2 indicates that the 2 week and 1 month visits are most likely provided as one visit for most children. In addition, the proportion of children receiving a visit falls as they age, indicating a role for reminders from providers to keep parents coming in for the visits. The HMO does have the highest proportion of children coming in for well-child visits during this timeframe, however, they have the lowest number of children enrolled within the Medicaid program.

Figure 2. Proportion of children with a well-child visit at each recommended time by managed care program, SFY 2007

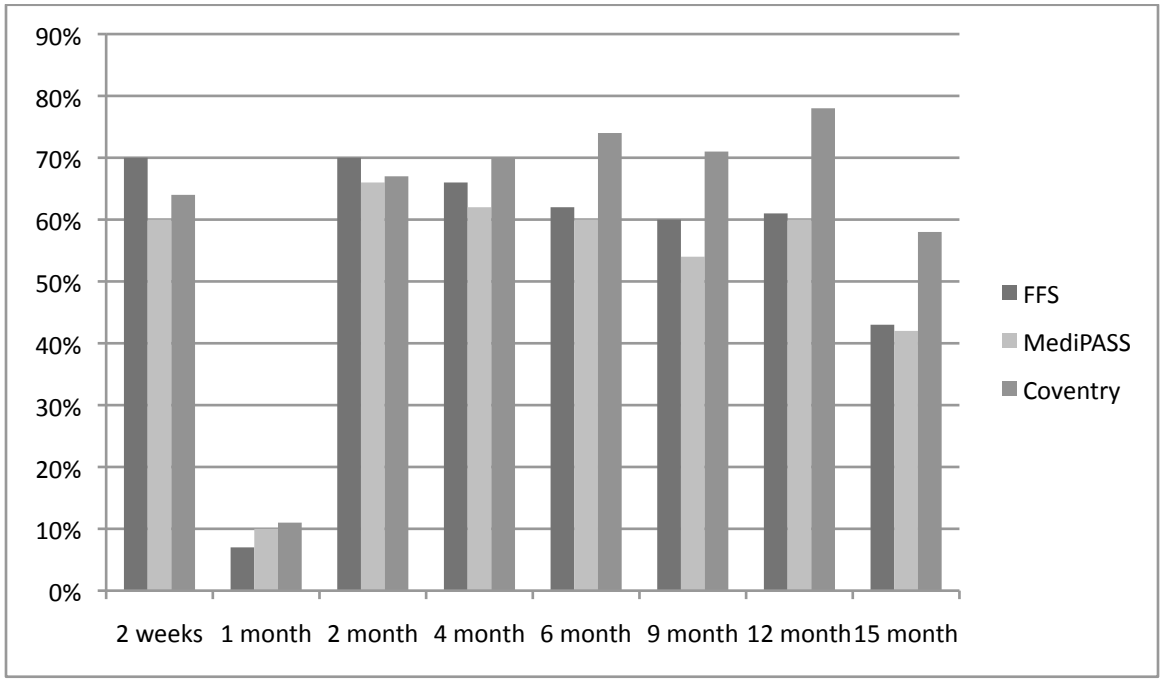
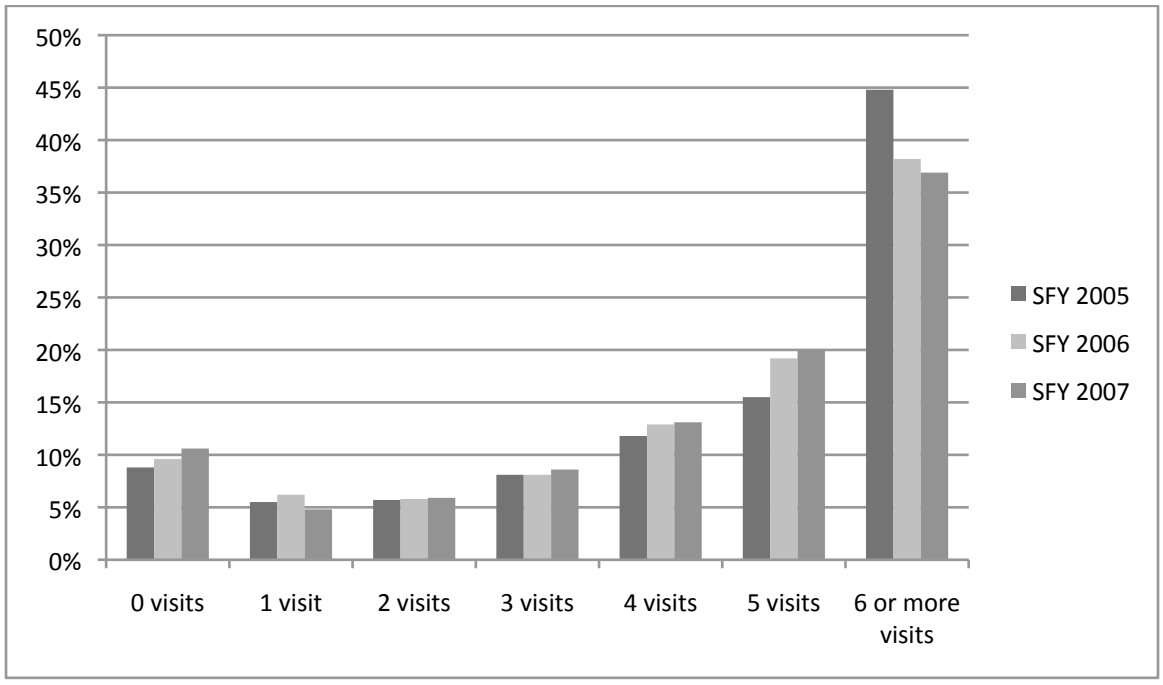


Figure 3 provides information regarding the 5 year trend for well-child visits in the first 15 months of life. For this figure, all the programs are combined to simplify the analysis. Though the proportion of children with six or more well-child visits is highest with regard to number of visits, this proportion has been falling over time, while the proportion of children with fewer than six visits has been rising. In particular, the proportion of children with zero well-child visits within our claims database has increased. This may reflect either an increase in the number of children who did not get a well-child visit or an increase in the number of children who received a visit at a facility, such as a community health clinic, that does not bill under a CPT code recognizable as a well-child visit under HEDIS protocols.

The recommended performance targets for this population are listed in Appendix A. The performance target for six or more visits should be set at 42% (COULD YOU INDICATE WHY THIS % WAS SET?). Though the rate did not fall significantly from SFY 2006 to SFY 2007, the fact that it did not increase should provide an impetus for the state to redouble its attempts to find every child a medical home and communicate the importance of regular well-child visits to providers and parents alike.

Figure 3 Proportion of children by number of well-child visits in the first 15 months of life and measurement year



Well-child visits in the third, fourth, fifth, and sixth years of life

During early childhood, three to six years of age, annual well-child visits are recommended to address issues of mobility, developmental milestones, added health risks, and anticipatory guidance.

We included all children who turned three, four, five, or six years of age during SFY 2007 and were enrolled for at least 11 months during this period in the denominator. Children who had a well-child visit as indicated by a procedure code or diagnosis code were included in the numerator. Table 3 indicates the proportion of children that got a well-child visit by program and age. Rates for SFY 2007 are lowest for the HMO with only 61% of all children three to six years of age receiving a well child visit annually.

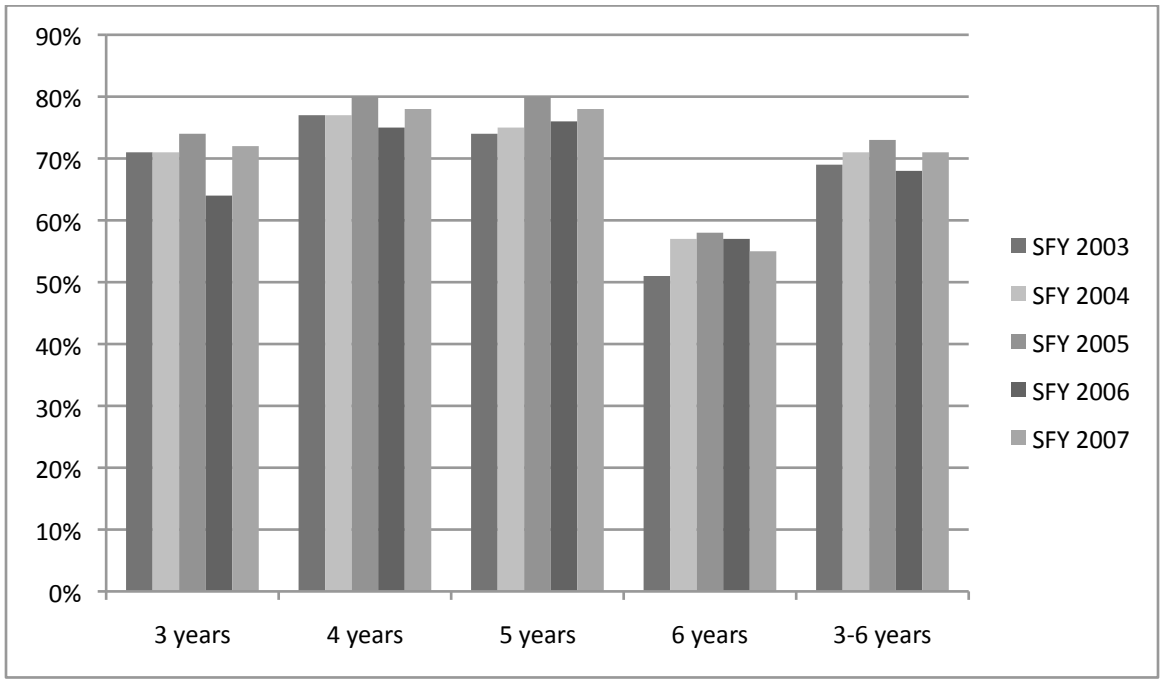
Table 2. Proportion of children receiving a well-child visit by program and age, SFY 2007

Age		FFS	MediPASS	HMO
3 years	Number	1499	4584	137
	%	71%	73%	59%
4 years	Number	1584	4589	135
	%	77%	78%	74%
5 years	Number	1480	4419	122
	%	78%	78%	66%
6 years	Number	1067	3026	95
	%	56%	55%	47%
3-6 years	Number	5630	16618	489
	%	71%	71%	61.0%

Figure 4 provides a visual representation of the rates over the last 5 years by age and year. The proportion of children receiving a well-child visit increased for all but six year olds from SFY 2006 to SFY 2007. However, the general pattern of fewer children having a well-child visit in the six year old group remained. The SFY 2007 combined rate for all children of 70.8% is only one percent below the rate for Wellmark (71.8%), leading us to conclude that children enrolled in Medicaid are receiving well-child care at rates comparable to privately insured children. The performance rate targets for children three to five years of age should be set at 75%, while the performance rate target for children six years of age should be set at 65%.

Over the past few years, rates have consistently shown that the proportion of children getting a well-child visit drops significantly for six year olds. Up until children enter the public school system they are required to have immunizations at various times, without these immunizations children are not allowed to enter public school. However, once they have entered public school it appears that the import of the well-child visit is reduced. Partnering with the schools to require well-child visits at regular intervals may be one method for increasing the well-child rates.

Figure 4 Proportion of children with a well-child visit by age and year



Annual dental visit

Regular dental visits are important, not just for oral health, but for the health of the whole body. Though it is recommended that children begin to see a dentist as early as age 6 months, most children will not access any dental services until they are at least three years old. Early access can ensure a proper understanding of oral hygiene, early identification of risks for decay, and counseling regarding nutrition and fluoridation. As children age, dental visits continue to provide an opportunity to monitor hygiene and treat oral disease, as well as, to provide anticipatory guidance. We have included foster children in this measure to help us understand how this vulnerable population compares to our Medicaid managed care population. Children in foster care may be at greater than normal risk for oral health problems due to abuse or neglect, making their access to dental services even more critical than for the general population.

All dental care in the Iowa Medicaid program is provided through the traditional fee-for-service approach, with care provided by any dentists with an Iowa Medicaid provider number, willing to provide services at Iowa Medicaid reimbursement rates. There is no managed dental care in Iowa, including enrollees in Coventry and MediPASS.

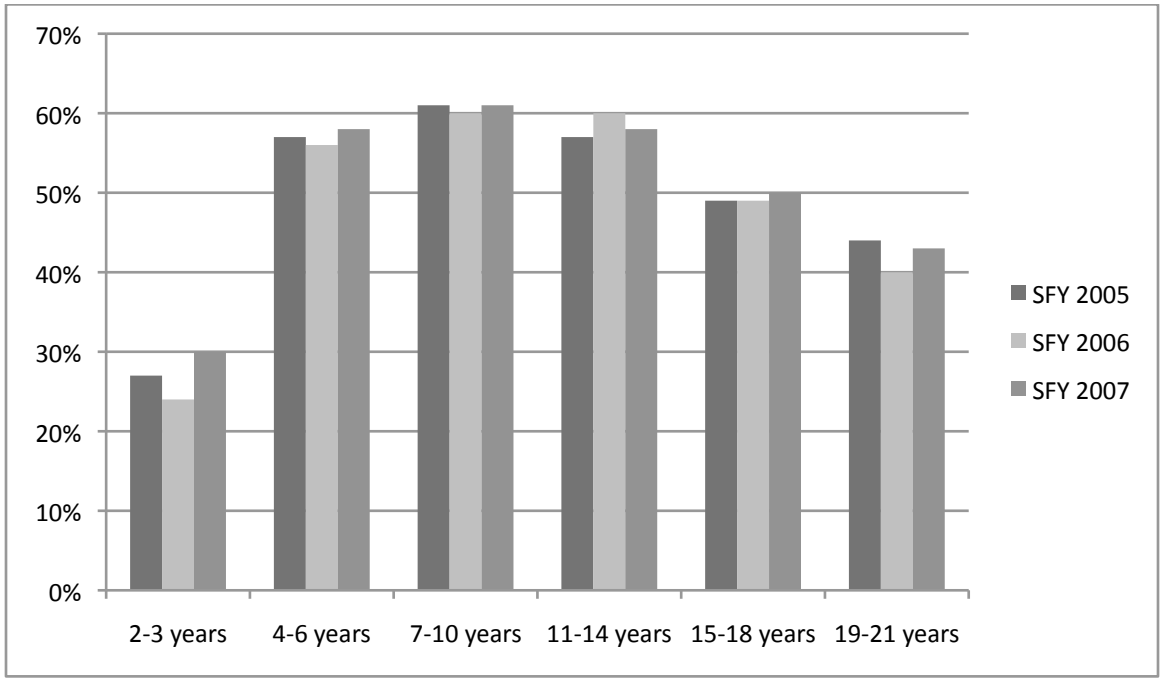
Within the Medicaid managed care population and the population of children in foster care, children ages two to three years have the lowest likelihood of having an annual dental visit. Within the HMO no age group has a proportion greater than 50% with an annual dental visit, while for MediPASS and FFS most of the age groups have over 50% of the children and adolescents accessing dental services. When comparing children in Medicaid managed care to foster children there are two different trends evident. For children in Medicaid managed care, the proportion with an annual dental visit falls as they age, whereas for children in foster care the proportion rises as they age.

Table 3. Proportion of children and adolescents with an annual dental visit by age and program, SFY 2007

Age		FFS	MediPASS	HMO	Foster Care
2-3 years	Number	1202	3795	81	81
	%	27%	30%	17%	23%
4-6 years	Number	3001	9916	279	103
	%	51%	58%	49%	66%
7-10 years	Number	3668	11618	313	229
	%	55%	61%	48%	76%
11-14 years	Number	2965	8888	235	336
	%	53%	58%	46%	82%
15-18 years	Number	2127	6113	173	728
	%	47%	50%	46%	83%
19-21 years	Number	717	1508	50	N/A
	%	43%	43%	39%	

Over the last three years, the rates have remained relatively stable. Figure 5 provides the rates over time for the MediPASS program, the program with the largest enrollment. The pattern of utilization across ages has not changed over time. Children 7-10 years old are the most likely to receive an annual dental visit, while children 2-3 years old are least likely. The performance targets must be set by age group: 35% for children 2-3 years old, 65% for children 4-6 years old and children 7-10 years old, 60% for adolescents 11-14 years old and adolescents 15-18 years old, and 45% for young adults 19-21 years old. The most effective method for increasing the rates would be the fulfillment of the goal of recent legislation that every child in the Medicaid program have a dental home.

Figure 5. Proportion of children within the MediPASS program with an annual dental visit by age and measurement year



Children and adolescents' access to primary care practitioners

Rates of access to primary care practitioners provide a very general measure of access. Though the type of care received is not defined, the percentage of children and adolescents that had a practitioner available to see them when the need arose is available. This rate includes well-child visits as well as visits for acute or chronic sick care. The denominator consists of children who turned 12-24 months, 25 months to six years, seven to eleven years, and 12-19 years during the measurement year. Children 12 months to six years had to be eligible for at least 11 months during SFY 2007, while children and adolescents 7-19 years old had to be eligible for at least 11 months during SFY 2007 and at least 11 months during SFY 2006. We modify this measure to include not only visits to practitioners identified as primary care, but to any practitioner with the understanding that being able to access the system at any point, whether for specialty care or primary care provides an inlet to further services.

The proportions of children and adolescents with access to primary care practitioners are listed in Table 4. The rates are high with every age group within each program achieving a overall rate of over 90%. 99% of children 12-24 months within all three programs had access to practitioners. These rates are reassuring, given the proportion of children who do not receive any well-child visits in the first 15 months of life. Though preventive care is important, these rates indicate that a lack of well care does not translate into a complete avoidance of needed ambulatory care.

Table 4. Proportion of children and adolescents' with access to primary care practitioners, SFY 2007

Age		FFS	MediPASS	HMO
12-24 months	Number	2928	8539	335
	%	99%	99%	99%
25 months-6 years	Number	7602	22550	776
	%	93%	95%	93%
7-11 years	Number	5953	17926	674
	%	91%	93%	92%
12-19 years	Number	6781	19759	652
	%	89%	91%	91%
Total	Number	23264	68774	2437
	%	92%	94%	93%

Use of appropriate medications for people with asthma

In determining the proportion of people who are placed on appropriate medications for their asthma we utilized the only disease specific measure in the current HEDIS set relevant to a Medicaid population. Though HEDIS has many disease specific measures, most are not appropriate for children or young women, the majority of the managed care population. This measure applies to young and old alike and is not gender specific, making it perfect for a snapshot on chronic care for Medicaid enrollees.

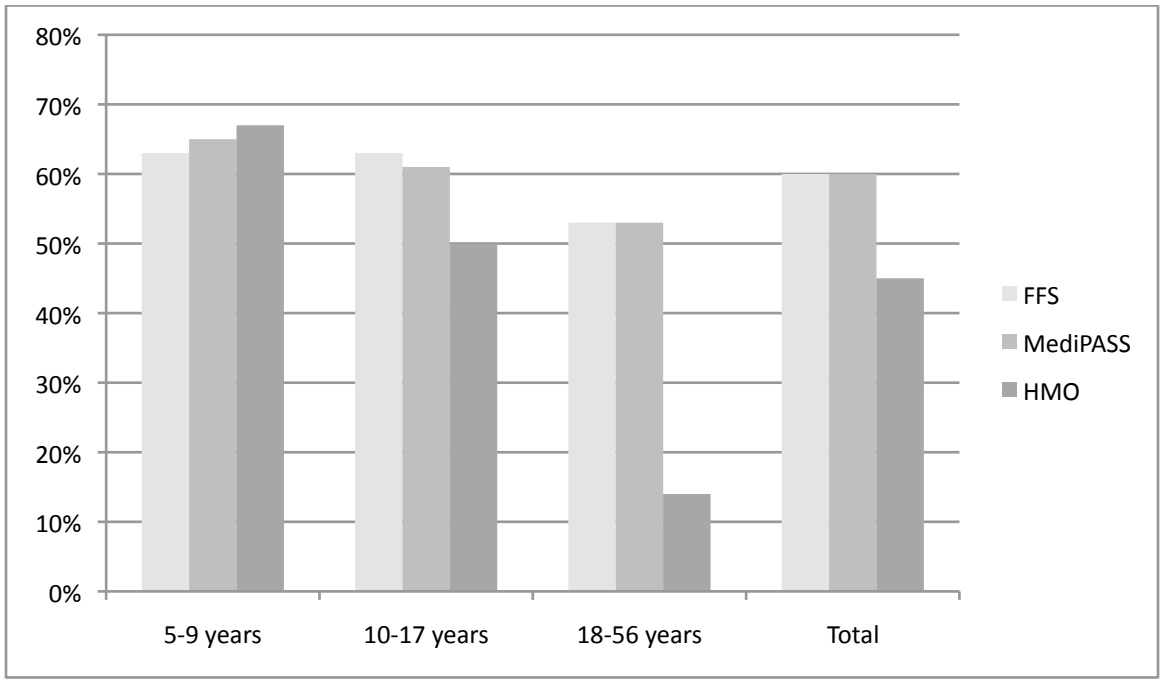
The denominator for this measure consists of individuals who have been enrolled for at least 11 months during SFY 2007 and at least 11 months during SFY 2006 and met the case finding criteria for persistent asthma (see Appendix F). The numerator consists of individuals within the denominator who were prescribed primary asthma therapy. Though we have calculated this measure for over five years, it changes every year due to changes in therapies. Therefore, though the rates for all five years are included in the appendices, comparison charts or graphs are not helpful. Table 5 provides the proportion of children and adults with persistent asthma by program. The rates were consistent across both program and age group with approximately 1% of enrollees having persistent asthma.

Table 5. Proportion of children and adults with persistent asthma, SFY 2007

Age		FFS	MediPASS	HMO
5-9 years	Number	76	202	9
	%	1%	1%	1%
10-17 years	Number	72	199	4
	%	1%	1%	1%
18-56 years	Number	79	160	7
	%	1%	1%	1%
Total	Number	227	561	20
	%	1%	1%	1%

The proportions of children and adults using the appropriate medication for asthma are shown in Figure 6. The most surprising finding within the figure is the low rate for adults 18-56 years old in the HMO who are receiving appropriate medications for asthma. Because the numbers of children and adults with asthma are quite low in the HMO group; less than 10 in each group, we need to interpret the results with great care. One or two individuals without record of the appropriate medications can change the proportion by over 12%, therefore, though the rates for the HMO are provided, they are not helpful for outcome purposes. Performance target rates for this measure may be set at 75% for all age groups, however, the HMO should not be held to these targets due to the small population of people with persistent asthma.

Figure 6. Proportion of children and adults using appropriate medications for asthma, SFY 2007



Adults' access to preventive/ambulatory health services

Though adults do not comprise a large share of the Medicaid managed care eligible population, they are still an important population to be considered. It is imperative that this population have adequate access to medical services to ensure the rapid diagnosis and proper treatment for not only acute problems, but chronic illnesses that may be emerging. The denominators for these rates include all adults who turned 20-44 years of age or 45-64 years of age during SFY 2007. The numerators for the rates include the adults in the denominator who had at least one preventive or ambulatory visit during SFY 2007. Adults 65 years of age and older are not included in this report as they comprise less than 1% of the Medicaid managed care population. The rates for adults' access to preventive/ambulatory health services are given in Table 6. Rates are over 75% for the 45-64 year olds regardless of the program and over 85% for the 20-44 year olds. These rates indicate that access to medical care is high. Performance targets should be set at 90% for both age groups across all three programs.

Table 6. Adults' access to preventive/ambulatory health services by program and age, SFY 2007

Age		FFS	MediPASS	HMO
20-44 years	Number	6012	10801	473
	%	87.0%	88.8%	94.0%
45-64 years	Number	698	1056	30
	%	77.4%	86.1%	78.9%

Prenatal and postpartum care

The prenatal care rate is the proportion of women with a delivery who received a prenatal care visit within the first trimester or within 42 days of enrollment. The postpartum care rate is the proportion of women with a delivery who had a postpartum visit on or between 21 and 56 days of delivery. The denominator for both rates is the number of women with a live delivery between May 6, 2006 and May 5, 2007, who were continuously enrolled for 43 days prior to delivery through 56 days after delivery. The numerator for the prenatal care rate is the number of women in the denominator who had a prenatal care visit in the first trimester of care or within 42 days of becoming eligible. The numerator for the postpartum care rate is the number of women in the denominator who had a postpartum care visit between 21 and 56 days after delivery.

Between 6 May 2006 and 5 May 2007 there were 12,732 live birth deliveries identified for which the mother was continuously enrolled between 43 days prior to the delivery and 56 days after the delivery.

Table 7 provides the rate of prenatal care based on the time for which the woman was enrolled in Medicaid. The overall rate of prenatal care was 68.9% in SFY 2007, compared with 68.6% in SFY 2006. Between 2005 and 2006 the HEDIS definition used to determine prenatal care changed slightly. The new definition expanded the code base used to identify a prenatal visit and also relaxed the conditions placed on the codes to qualify as a prenatal visit. The result of these changes increases the number of women classified as having received early prenatal care. Therefore rates in previous reports are no longer directly comparable to the current estimates.

Women who had bundled prenatal care codes were far more likely to have received early prenatal care than those without bundled care (78.9% c.f. 24.0%). Women continuously enrolled for the first trimester were more likely to have received early prenatal care than women whose enrollment commenced during the first trimester (81.1% c.f. 74.3%). Approximately 50% of women who were not enrolled until after the first trimester received timely prenatal care.

Rates of postpartum care are presented in Table 8. The rate of postpartum care declined from SFY 2006 to SFY 2007 from 38.4% to 34.4%. A number of women have Healthcare Common Procedure Coding System (HCPCS) codes indicative of postpartum care received at a maternal health center or a rural health center. These codes have been included to be indicative of postpartum care in Table 8. Furthermore, if all women with a bundled postpartum code were assumed to have received a postpartum visit then the rate for 2007 would be 86.1% and the rate for 2006 would be 84.2%. HCPCS are not used to in the HEDIS definitions and are, therefore, not routinely used in these outcome analyses. It seems reasonable to modify the HEDIS outcome measures for prenatal and postpartum care to reflect the care received at maternal health centers and rural health centers by including HCPCS codes.

Table 7. Rates of early prenatal care, SFY 2006 and SFY 2007

Enrollment period	Prenatal care not bundled	Bundled prenatal care	Total
Continuously enrolled for first trimester			
2007	36.9%	88.1%	81.1%
2006	45.7%	90.3%	81.4%
Last enrollment segment commenced on or between 219 and 279 days prior to the EDD			
2007	25.9%	83.8%	74.3%
2006	31.7%	86.1%	74.1%
Last enrollment segment commenced less than 219 days prior to the EDD			
2007	15.3%	61.5%	49.9%
2006	14.9%	65.6%	51.1%
Total			
2007	24.0%	78.9%	68.9%
2006	28.5%	81.1%	68.6%

Table 8. Rates of postpartum care, SFY 2006 and SFY 2007

Year	Postpartum care not bundled	Bundled Postpartum care	Total
2007†	33.3%	34.6%	34.4%
2006†	39.0%	38.2%	38.4%

† Using an expanded definition that includes codes indicative of postpartum care received at a maternal health center or a rural health center.

Tables 9 and 10 list the rates of prenatal and postpartum care by year and Medicaid group. Rates of prenatal care ranged from 66.2% among the fee-for-service group to 76.5% for the HMO group. Postpartum care rates ranged from 32.7% for MediPASS to 55.4% for the HMO group. The performance targets for prenatal and postpartum care should be set at 55% for all programs.

Table 9. Rates of prenatal care by program, SFY 2006 and SFY 2007

Program	2007	2006
HMO	76.5%	67.2%
MediPASS	69.9%	70.4%
Fee-for-service	66.2%	65.0%

Table 10. Rates of postpartum care by program, SFY 2006 and SFY 2007

Program	2007†	2006†
HMO	55.4%	42.4%
MediPASS	32.7%	36.1%
Fee-for-service	35.9%	46.8%

† Using an expanded definition that includes codes indicative of postpartum care received at a maternal health center or a rural health center.

Comprehensive diabetes care: Hemoglobin A1c testing

The HEDIS measure for comprehensive diabetes care includes Hemoglobin A1c testing, HbA1c poor control, HbA1c good control, eye exam, LDL-C screening performed, LDL-C control, medical attention for nephropathy, and blood pressure control. Many of these components are available primarily through chart review and are not designed to be calculated from administrative data. We have chosen hemoglobin A1c testing as an easy, effective method to determine whether proper monitoring of diabetes is occurring. The denominator for this measure includes all enrollees 18 to 75 years old identified as having diabetes and enrolled for at least 11 months during SFY 2007. The numerator consists of all enrollees in the denominator with hemoglobin A1c testing done during SFY 2007. The proportion of enrollees with diabetes that had hemoglobin A1c testing is shown in Table 11 by program. The proportion of adults with testing is highest in MediPASS and lowest in the HMO, however, due to the small numbers of enrollees identified with diabetes in the HMO population (38), the rate should be interpreted with great care.

Table 11. Proportion of adults with diabetes that had a Hemoglobin A1c test, SFY 2007

Age		FFS	MediPASS	HMO
18-75 years	Number	220	500	22
	%	61%	73%	58%

Appendix A: Summary of Outcomes by managed care plan, SFY 2007

Measure	Coventry	MediPASS	FFS	Performance Target
Well-child visits in the first 15 months of life				
0 visits	9.3%	9.9%	8.4%	7.5%
1 visit	6.3%	5.2%	5.0%	4.5%
2 visits	7.4%	5.9%	6.2%	5.0%
3 visits	12.1%	8.8%	9.0%	8.0%
4 visits	14.2%	12.6%	14.1%	13.0%
5 visits	17.9%	20.5%	19.4%	20.0%
6 or more visits	33.7%	37.0%	37.1%	42.0%
Well-child visits in the third, fourth, fifth and sixth year of life				
Visit in the 3rd year of life	58.5%	72.9%	71.3%	75.0%
Visit in the 4th year of life	73.8%	78.0%	76.7%	75.0%
Visit in the 5th year of life	65.6%	78.1%	77.7%	75.0%
Visit in the 6th year of life	47.0%	55.0%	55.7%	65.0%
Visit in 3rd-6th years of life	60.7%	71.2%	70.5%	68.0%
Annual dental visit				
2–3 years old	16.6%	29.6%	27.1%	35.0%
4–6 years old	48.9%	58.2%	51.0%	65.0%
7–10 years old	47.5%	61.0%	55.1%	65.0%
11–14 years old	45.7%	58.0%	52.9%	60.0%
15–18 years old	46.0%	50.2%	47.3%	60.0%
19-21 years old	38.8%	42.8%	42.9%	45.0%
Children's and adolescents' access to primary care practitioners				
12–24 months old	99.1%	99.4%	98.9%	99.0%
2–6 years old	93.0%	94.6%	92.5%	95.0%
7–11 years old	92.2%	93.2%	90.9%	95.0%
12–19 years old	91.3%	91.2%	88.6%	95.0%
Combined	93.1%	93.8%	91.6%	95.0%
Use of appropriate medications for people with asthma				
5–9 years old	66.7%	65.3%	63.2%	75.0%
10–17 years old	50.0%	61.3%	62.5%	75.0%
18–56 years old	14.3%	53.1%	53.2%	75.0%
Combined	45.0%	60.4%	59.5%	75.0%
Adult's access to preventive/ambulatory health services				
20–44 years old	94.0%	88.8%	87.0%	90.0%
45–64 years old	78.9%	86.1%	77.4%	90.0%
Prenatal and postpartum care				
Prenatal care	76.5%	69.9%	66.2%	75.0%
Postpartum care	55.4%	32.7%	35.9%	75.0%
Comprehensive diabetes care				
Hemoglobin A1c	57.9%	72.7%	60.9%	75.0%

Appendix B: Summary of Outcomes by managed care plan, SFY 2006

Measure	Coventry	MediPASS	FFS
Well-child visits in the first 15 months of life			
0 visits	1.7%	10.0%	9.4%
1 visit	3.7%	6.5%	5.5%
2 visits	9.4%	5.5%	6.1%
3 visits	12.7%	7.7%	8.8%
4 visits	13.7%	12.5%	13.9%
5 visits	21.7%	18.7%	20.3%
6 or more visits	37.1%	39.0%	36.1%
Well-child visits in the third, fourth, fifth and sixth year of life			
Visit in the 3rd year of life	48.6%	65.3%	63.3%
Visit in the 4th year of life	55.6%	75.4%	74.1%
Visit in the 5th year of life	53.8%	77.6%	74.8%
Visit in the 6th year of life	35.6%	58.2%	55.6%
Visit in 3rd-6th years of life	48.3%	69.3%	67.0%
Annual dental visit (new categories)			
2–3 years old	15.5%	24.2%	23.9%
4–6 years old	46.3%	55.6%	51.2%
7–10 years old	50.8%	59.2%	53.5%
11–14 years old	46.4%	55.5%	49.7%
15–18 years old	46.0%	48.7%	45.2%
19-21 years old	40.4%	39.9%	42.7%
Children's and adolescents' access to primary care practitioners			
12–24 months old	97.5%	81.2%	84.5%
2–6 years old	83.9%	67.0%	64.3%
7–11 years old	87.4%	78.4%	79.5%
12–19 years old	89.8%	77.5%	79.0%
Combined	87.8%	73.7%	73.4%
Use of appropriate medications for people with asthma			
5–9 years old	83.3%	84.7%	78.3%
10–17 years old	63.6%	84.6%	80.9%
18–56 years old	61.1%	80.9%	75.8%
Combined	68.3%	83.5%	78.3%
Adult's access to preventive/ambulatory health services			
20–44 years old	87.3%	85.0%	83.9%
45–64 years old	88.4%	84.6%	76.4%
Prenatal and postpartum care			
Prenatal care	67.2%	70.4%	65.0%
Postpartum care	42.4%	36.1%	46.8%
Comprehensive diabetes care			
Hemoglobin A1c	57.5%	70.3%	61.9%

N/A-No rate provided in NCQA audited means, percentiles and ratios

Appendix C: Summary of Outcomes by managed care plan, SFY 2005

Measure	Coventry	MediPASS	FFS	IHS to MediPASS	IHS to FFS
Well-child visits in the first 15 months of life					
0 visits	2.1%	11.9%	8.1%	1.9%	2.0%
1 visit	3.8%	6.4%	5.0%	3.7%	2.6%
2 visits	4.3%	5.8%	6.7%	4.8%	5.1%
3 visits	9.0%	7.3%	8.3%	10.5%	7.5%
4 visits	14.5%	11.3%	12.0%	13.3%	11.4%
5 visits	21.8%	15.0%	15.2%	14.2%	19.1%
6 or more visits	44.4%	42.2%	44.7%	51.5%	52.3%
Well-child visits in the third, fourth, fifth and sixth year of life					
Visit in the 3rd year of life	73.2%	76.6%	74.2%	76.2%	82.7%
Visit in the 4th year of life	79.0%	80.1%	78.7%	79.9%	87.8%
Visit in the 5th year of life	79.7%	81.2%	77.3%	80.0%	85.2%
Visit in the 6th year of life	31.2%	63.5%	55.5%	54.5%	57.4%
Visit in 3rd-6th years of life	66.9%	74.8%	71.6%	73.1%	80.4%
Annual dental visit (new categories)					
2–3 years old	17.8%	26.6%	26.8%	28.9%	32.1%
4–6 years old	55.2%	57.4%	52.7%	56.9%	61.5%
7–10 years old	56.9%	61.1%	54.3%	58.8%	60.0%
11–14 years old	50.9%	56.9%	52.0%	54.2%	55.6%
15–18 years old	49.4%	49.4%	47.1%	45.0%	50.5%
19-21 years old	41.4%	43.5%	41.0%	38.8%	41.1%
Annual dental visit (old categories)					
1–3 years old	11.8%	19.0%	19.5%	20.3%	23.6%
4–6 years old	55.2%	57.4%	52.7%	56.9%	61.5%
7–11 years old	55.9%	60.8%	54.4%	58.7%	59.5%
12–15 years old	50.2%	54.6%	51.3%	51.0%	53.9%
16–18 years old	49.8%	49.3%	45.1%	45.0%	50.5%
Children's and adolescents' access to primary care practitioners					
12–24 months old	99.6%	99.2%	97.2%	99.2%	100.0%
2–6 years old	86.8%	93.9%	90.4%	92.6%	93.8%
7–11 years old	88.3%	91.2%	89.4%	91.7%	93.1%
12–19 years old	86.9%	91.9%	89.9%	91.4%	94.1%
Combined	89.2%	93.3%	90.7%	93.1%	94.7%
Use of appropriate medications for people with asthma					
5–9 years old	57.1%	92.4%	95.7%	76.9%	80.0%
10–17 years old	100.0%	95.1%	90.0%	78.4%	78.9%
18–56 years old	80.0%	85.2%	81.0%	84.8%	81.0%
Combined	77.3%	91.4%	88.1%	79.5%	80.0%
Adult's access to preventive/ambulatory health services					
20–44 years old	87.8%	85.1%	84.5%	84.3%	90.7%
45–64 years old	88.2%	85.3%	62.3%	84.9%	85.7%
Prenatal and postpartum care					
Prenatal care	43.1%	65.8%	58.1%	55.3%	52.4%
Postpartum care	52.7%	35.3%	36.1%	23.5%	25.2%
Comprehensive diabetes care					
Hemoglobin A1c	54.3%	33.9%	28.5%	40.6%	60.0%

Appendix D: Summary of Outcomes by managed care plan, SFY 2004

Measure	John Deere	Coventry	Iowa Health Solutions	MediPASS
Well-child visits in the first 15 months of life				
0 visits	3.1%	0.0%	1.0%	0.2%
1 visit	8.5%	0.0%	2.6%	0.7%
2 visits	6.3%	4.3%	7.1%	2.0%
3 visits	11.6%	14.9%	13.6%	2.6%
4 visits	15.9%	19.1%	23.3%	6.7%
5 visits	19.8%	38.3%	26.4%	10.1%
6 or more visits	34.8%	23.4%	26.0%	77.7%
Well-child visits in the third, fourth, fifth and sixth year of life				
Visit in the 3rd year of life	53.2%	72.5%	64.3%	76.4%
Visit in the 4th year of life	65.4%	80.2%	70.3%	80.8%
Visit in the 5th year of life	64.6%	82.8%	63.8%	80.8%
Visit in the 6th year of life	38.2%	20.1%	44.3%	63.5%
Visit in 3rd-6th years of life	56.2%	75.3%	61.3%	75.6%
Annual dental visit				
1–3 years old	28.0%	11.7%	21.2%	19.7%
4–6 years old	64.4%	55.4%	59.4%	60.9%
7–11 years old	62.3%	51.1%	59.6%	64.0%
12–15 years old	53.9%	52.4%	52.0%	58.1%
16–18 years old	46.4%	54.8%	45.1%	50.2%
Children's and adolescents' access to primary care practitioners				
12–24 months old	98.1%	100.0%	97.6%	92.4%
2–6 years old	87.1%	85.7%	88.7%	83.0%
7–11 years old	86.0%	88.8%	86.9%	82.6%
12–19 years old	89.7%	88.0%	84.6%	81.4%
Use of appropriate medications for people with asthma				
5–9 years old	40.6%	50.0%	63.3%	79.9%
10–17 years old	52.9%	75.0%	58.0%	70.6%
18–56 years old	50.0%	20.0%	55.3%	55.1%
Combined	47.8%	38.9%	57.8%	69.3%
Adult's access to preventive/ambulatory health services				
20–44 years old	85.1%	88.8%	88.7%	81.0%
45–64 years old	78.8%	81.3%	86.5%	85.5%
Prenatal and postpartum care				
Prenatal care	63.0%	55.5%	63.0%	63.8%
Postpartum care	—	—	—	—
Comprehensive diabetes care				
Hemoglobin A1c	84.8%	90.0%	20.0%	27.9%

Appendix E: Summary of Outcomes by managed care plan, SFY 2003

Measure	John Deere	Coventry	Iowa Health Solutions	MediPASS
Well-child visits in the first 15 months of life				
0 visits	1.5%	0.0%	0.2%	0.3%
1 visit	8.7%	1.1%	4.0%	1.8%
2 visits	9.0%	2.2%	5.2%	2.2%
3 visits	10.0%	9.7%	8.9%	4.3%
4 visits	12.6%	29.0%	12.6%	6.9%
5 visits	15.9%	24.7%	19.1%	11.6%
6 or more visits	42.2%	33.3%	50.1%	73.0%
Well-child visits in the third, fourth, fifth and sixth year of life				
Visit in the 3rd year of life	56.1%	89.4%	73.4%	77.6%
Visit in the 4th year of life	62.7%	85.3%	78.7%	82.8%
Visit in the 5th year of life	58.8%	73.6%	75.9%	81.7%
Visit in the 6th year of life	37.8%	55.7%	43.3%	61.2%
Visit in the 3rd-6th years of life	53.9%	76.7%	68.9%	76.2%
Annual dental visit				
1–3 years old	21.9%	18.0%	21.3%	18.7%
4–6 years old	62.7%	54.3%	57.2%	54.3%
7–11 years old	62.9%	50.9%	57.9%	63.5%
12–15 years old	56.2%	46.5%	51.3%	57.0%
16–18 years old	47.5%	47.0%	45.8%	51.2%
Children's and adolescents' access to primary care practitioners				
12–24 months old	71.9%	91.0%	90.0%	92.8%
2–6 years old	59.2%	69.7%	73.2%	83.6%
7–11 years old	75.2%	72.7%	76.9%	82.7%
12–19 years old	72.3%	77.1%	74.5%	82.1%
Use of appropriate medications for people with asthma				
5–9 years old	55.6%	33.3%	55.8%	58.4%
10–17 years old	51.5%	25.0%	62.7%	57.1%
18–56 years old	55.4%	42.9%	40.5%	56.9%
Combined	54.2%	33.3%	54.7%	57.5%
Adult's access to preventive/ambulatory health services				
20–44 years old	69.5%	88.8%	87.2%	84.6%
45–64 years old	63.6%	70.6%	87.7%	83.4%
Prenatal and postpartum care				
Prenatal care	60.4%	53.5%	63.5%	65.2%
Postpartum care	—	—	—	—
Comprehensive diabetes care				
Hemoglobin A1c	51.3%	46.2%	48.2%	28.7%

Appendix F: Technical specifications for outcome measures

Well-child visits in the first 15 months of life

Denominator: Children who turn 15 months of age during the measurement year and are continuously eligible for the period from 31 days of age through 15 months of age with no more than a 1-month gap. Whether children are 31 days of age is calculated by adding 31 days to the date of birth and whether they are 15 months is calculated as the date of the first birthday plus 90 days.

Numerator: Children within the denominator who had a well-child visit defined by any one of the procedure codes: 99381, 99382, 99391, 99392, 99432 or one of the diagnosis codes: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9.

Rates: Seven rates are computed for this measure. These rates encompass the proportion of children that had 0, 1, 2, 3, 4, 5, *or* 6 or more well visits during the 15-month period.

Well-child visits in the third, fourth, fifth, and sixth year of life

Denominator: Children who turn three through six years of age during the measurement year and are eligible for at least 11 months during the measurement year.

Numerator: Children within the denominator who had a well-child visit defined by any one of the procedure codes: 99382, 99383, 99392, 99393 or one of the diagnosis codes: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9.

Rates: Five rates are calculated, one for each year of age and one combined.

Annual dental visit

Denominator: Children 2–21 years of age who are eligible for at least 11 months during the measurement year.

Numerator: Children within the denominator who had a visit with a dental provider during the measurement year.

Rates: The rate is calculated for six age groups: 2–3 years old, 4–6 years old, 7–10 years old, 11–14 years old, 15–18 years old, and 19-21 years old.

Children's and adolescent's access to primary care practitioners

Denominator: Children who turn 12 months–6 years of age during the measurement year and who are eligible for at least 11 months during the measurement year *and* children 7 years of age to adolescents 19 years of age who are eligible for at least 11 months during the measurement year and 11 months during the year prior to the measurement year.

Numerator: Children 12 months–6 years of age who have had a primary care visit during the measurement year *and* children 7 years of age through adolescents 19 years of age who have had a primary care visit during the measurement year or the year prior to the measurement year. A primary care visit was defined as any visit with one of the procedure codes: 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99401-99404, 99411, 99412, 99420, 99429, 99381-99385 or 99391-99395 or one of the diagnosis codes: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9.

Rates: This rate is calculated for four different age groups: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years.

Use of appropriate medications for people with asthma

Denominator: People ages 5–56 years old who are eligible for at least 11 months during the measurement year and 11 months during the year prior to the measurement year with persistent asthma. People are considered to have persistent asthma if they meet one of the four protocols listed below during both the year *prior* to the measurement year and the measurement year.

> At least one emergency visit defined by one of the procedure codes: 99281-99285 or one of the revenue codes: 450-459, 981 and with a principal diagnosis of asthma (ICD-9-CM 493).
>
> At least one hospital discharge defined by one of the procedure codes: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, or 99291 or one of the revenue codes: 100-149, 119, 120-124, 129, 150-154, 159, 160-169, 200-229, 720-729, or 987 and with a principal diagnosis of asthma (ICD-9-CM 493).
>
> Have at least 4 outpatient/physician visits defined by one of the procedure codes: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429 or 99499 or one of the revenue codes: 510-519, 520-523, 529, 570-599, 770-779, 982 or 983 and with any diagnosis of asthma (ICD-9-CM 493).
>
> Have at least four asthma-medicine dispensing events. A list of asthma medications is found on the NCQA website.

Numerator: The numerator consists of those people in the denominator who had at least one medication-prescribing event for a long-term control medication during the measurement year. A list of these medications is found on the NCQA website.

Rates: This rate is calculated for four different age groups: 5–9 years olds, 10–17 year olds, 18–56 year olds, and a combined rate containing everyone 5–56 years old.

Adult access to preventive/ambulatory health services

Denominator: Adults 20-64 years of age who are eligible for at least 11 months in the measurement year.

Numerator: Adults within the denominator who had a preventive/ambulatory visit within the measurement year. Preventive/ambulatory visits are defined as a visit with one of the procedure codes: 99210-99205, 99211-99215, 99241-99245, 99341-99350, 99301-99303, 99311-99313, 99321-99323, 99331-99333, 99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, 99429, 99499, 92002, 92004, 92012, 92014 or one of the revenue codes: 770, 771, 779, 510-529, 982, 983.

Rates: This rate is calculated for two age groups: 20–44 year olds and 45–64 year olds.

Prenatal and postpartum care

Denominator: Women with a live birth during the year ending 56 days before the end of the measurement year and who were eligible for the period 43 days prior to delivery through 56 days after delivery.

Live births were defined by one of the diagnosis codes: 72.0-73.99, 74.0-74.2, 74.4, 74.99, 640.01-640.91, 641.01-641.91, 642.01-642.91, 643.01-643.91, 644.21, 645.11, 645.21, 646.01-646.91, 646.12, 646.22, 646.42, 646.52, 646.62, 646.82, 647.01-647.92, 648.01-648.92, 651.01-652.91, 653.01-653.91, 654.01-654.91, 654.02, 654.12, 654.32, 654.42, 654.52, 654.62, 654.72, 654.82, 654.92, 655.01-655.91, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.01-658.91, 659.01-659.91, 660.01-660.91, 661.01-661.91, 662.01-662.91, 663.01-663.91, 664.01-664.91, 665.01, 665.11, 665.22, 665.31, 665.41, 665.51, 665.61, 665.71, 665.72, 665.81, 665.82, 665.91, 665.92, 666.02-666.92, 667.02-667.92, 668.01-668.91, 668.02-668.92, 669.01, 669.02, 669.11, 669.12, 669.21, 669.22, 669.32, 669.41, 669.42, 669.51, 669.61, 669.71, 669.81, 669.82, 669.91, 669.92, 670.02, 671.01, 671.02, 671.11, 671.12, 671.21, 671.22, 671.31, 671.42, 671.51, 671.52, 671.81, 671.82, 671.92, 671.92, 672.02, 673.01-673.91, 673.02-673.92, 674.01, 674.02-674.92, 675.01-675.91, 675.02-675.92, 676.01-676.91, 676.02-676.92 or one of the procedure codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 or one of the DRG codes: 370-375. Any claim with one of the diagnosis codes 630-637, 656.4, 768.0, 768.1, V27.1, V27.4, or V27.7 is considered *not* to represent a live birth.

Numerator: Women within the denominator who had a prenatal care visit in the first trimester or within 42 days of becoming eligible. See HEDIS 2004, Volume 2, Technical Specifications for greater detail. A prenatal visit is defined by one of the procedure codes: 59400, 59510, 59610, 59618, 59425, 59426 with a date indicating first prenatal visit or one of the procedure codes: 99201-99205, 99211-99215 or revenue code 514 in combination with one of the procedure codes or procedure code combinations: 76801, 76802, 76805, 76811, 76812, 76815, 76816, 76817, 76818, 80055, 80090, 86762 and 86900 or 86762 and 86901 or in combination with one of the diagnosis codes: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, V22-V23. Postpartum care was defined by one of the procedure codes: 57170, 58300, 59400,

59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 88141-88145, 88147, 88148, 88150-88155, 88164-88167, 88174, 88175 or one of the diagnosis codes: 91.46, V24.1, V24.2, V25.1, V72.3, V76.2 or revenue code 923.

Rates: Two rates are calculated, one for prenatal care and one for postpartum care.

Comprehensive diabetes care

Denominator: Adults with diabetes18–64 years of age who were eligible for at least 11 months in the measurement year *and* who met one of the following protocols during the measurement year or the year prior to the measurement year.

> At least one emergency visit defined by one of the procedure codes: 99281-99288 or one of the revenue codes: 450-459, 981 and with a principal diagnosis of diabetes (ICD-9-CM 250.00-250.99, 357.2, 362.0, 366.41, 648.0 or DRG 205 or 294) or one hospital discharge defined by one of the procedure codes: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, or 99291 or one of the revenue codes: 100-149, 119, 120-124, 129, 150-154, 159, 160-169, 200-229, 720-729, or 987 or DRG 462 and with a principal diagnosis of diabetes (ICD-9-CM 250.00-250.99, 357.2, 362.0, 366.41, 648.0 or DRG 205 or 294).
>
> At least 2 outpatient/physician/non-acute inpatient visits defined by one of the procedure codes: 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99289, 99290, 99301-99303, 99311-99313, 99321-99323, 99331-99333, 99341-99355, 99384-99387, 99394-99397, 99410-99404, 99411, 99412, 99420, 99429, 99499 or one of the revenue codes: 118, 128, 138, 148, 158, 190-199, 510-529, 550-559, 570-599, 660-669, 770-779, 820-859, 880-889, 982 or 983 and with a diagnosis of diabetes (ICD-9-CM 250.00-250.99, 357.2, 362.0, 366.41, 648.0).
>
> Have at least one diabetes medication dispensing event. A list of insulin and oral hypoglycemic medications is found on the NCQA website.

Numerator: Adults within the denominator who had a hemoglobin A1c test (procedure code 83036) during the measurement year.

Rates: One rate, including all adults, is calculated for this measure.

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A. ADMINISTRATIVE AUTHORITY: The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities. (Section A of the work plan outlines actions to collect, aggregate, report, and analyze data in accordance with performance measures specified in Appendix A (Waiver Administration and Operation) of the 3.5 Waiver Application.)

7. **Revised** - Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity	Performance Measure
Participant waiver enrollment	☒	☐	n/a – Level of care and plan of care are addressed under other functions. Financial eligibility determination is a DHS function.
Waiver enrollment managed against approved limits	☒	☐	n/a – Management of waiver enrollment is a DHS function through ISIS workflow and review of reports
Waiver expenditures managed against approved levels	☒	☐	n/a – Management of waiver expenditures is a DHS function through ISIS / MMIS
Level of care evaluation	☒	☒	**a.i.a.1- a.i.a.11**
Review of Participant service plans	☒	☐	n/a – This is a DHS function of service plan reviews conducted and documented through the ISIS workflow process.
Prior authorization of waiver services	☒	☐	n/a – Authorization of services is a DHS function. ISIS workflow allows specific waiver services and expenditures over the authorized limit is conducted through exceptions to policy
Utilization management	☐	☐	n/a - This is a DHS function through ISIS workflows and MMIS

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					reports on plan authorization, units not exceeding plan authorizations and utilization below plan requests.		
		Qualified provider enrollment	☒	☒	**a.i.b.1. - a.i.b.21.**		
		Execution of Medicaid provider agreements	☒	☒	**a.i.c.1. – a.i.c.4.**		
		Establishment of a statewide rate methodology	☒	☐	n/a – This is a DHS function through Chapter 79 administrative rules on allowed rates and establishment of rate setting methodology.		
		Rules, policies, procedures and information development governing the waiver program	☒	☐	n/a – Rules, policies and procedures governing the waivers are a DHS function.		
		Quality assurance and quality improvement activities	☒	☒	**a.i.d.1. - a.i.d.9.**		

PERFORMANCE MEASURES

Performance Measures (PM) related to each work plan action step is listed in the first column of the grid. For reference, all performance measures for this section are listed below.

a.i.a. Level of care evaluation

a.i.a.1. Medicaid review of the Medical Services Contractor quarterly reports, which must be submitted within 10 business days of the end of the reporting quarter. For the purposes of system monitoring and improvement, number and percentage of level of care appeals with a judgment for the member.

a.i.a.2. Number and percentage of monthly contract management reports, which include data on the timeliness and outcomes of level of care determinations, submitted within three (3) business days of the end of the reporting period.

a.i.a.3. Number and percentage of monthly performance monitoring report cards, which include data on the timeliness and outcomes of level of care determinations, submitted within ten (10) business days of the end of the reporting period.

a.i.a.4. Utilizing Medical Services DHS approved internal quality control procedures, the number and percentage of retrospective desk reviews, which indicate that level of care determinations were not accurately and appropriately completed.

a.i.a.5. Number and percentage of inaccurate or inappropriately completed level of care evaluations that were identified resulting in education and training of the applicable review coordinator.

a.i.a.6. Number and percentage of level of care determination operational procedure manual updates and training on changes provided within two (2) weeks of the upgrade.

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a.i.a.7. Number and percentage of inaccurate or untimely level of care determination responses/resolutions provided to the DHS Unit Managers Team within two (2) business days of receipt of requests made in any form (e.g., e-mail, phone) on routine issues or questions.

a.i.a.8. Number and percentage of inaccurate or untimely level of care determination responses/resolutions provided to the DHS Unit Managers Team within one (1) business day on emergency requests, as defined by the State.

a.i.a.9. Number and percentage of deficiencies identified and provided to DHS within two (2) business days of receipt of requests made in any form (e.g., e-mail, phone) on level of care determinations.

a.i.a.10. Number and percentage of corrective actions following identification of deficiencies provided to DHS within two (2) business days of receipt of requests made in any form (e.g., e-mail, phone) on level of care determinations.

a.i.a.11. Number and amount of compensation withholdings annually applied for inappropriate, inaccurate and/or untimely level of care determinations. The contractual withholdings schedule and specific conditions for said withholdings are set forth in MED-04-015-B Contract _Medical Services. If the total amount withheld for failure to perform a requirement or meet a standard under this Contract is greater than one hundred dollars ($100.00) for more than three (3) consecutive months during or after the term of the Contract the Contractor shall forfeit five (5%) of the withheld amount to DHS.

a.i.b. Qualified provider enrollment

a.i.b.1. The Provider Services Contractor shall conduct surveys using performance standards, instruments and methodology approved by DHS. In SFY 2008 and thereafter a statistically valid survey shall demonstrate that Medicaid providers are 20% more satisfied with provider services recruitment and enrollment processes (excluding claims payment and adjudication services) than in SFY 2005.

a.i.b.2. Using DHS approved Contractor internal control all enrollment information and responses to Medicaid providers by the Contractor must be consistent regarding accuracy and content.

a.i.b.3. The Provider Services Contractor shall demonstrate that the Iowa Medicaid provider network is sufficient to provide the same access to medical services as that available to members of the public who have comprehensive health insurance coverage.

a.i.b.4. Number and percentage of provider enrollment packets not sent to the provider no later than one business day following the receipt of the request from the provider.

a.i.b.5. Number and percentage of provider enrollment packets that are not processed according to contractual performance standards, those being, provider enrollment applications must be approved, assigned a provider number, entered in the provider file, denied, or returned to the provider for additional information within 5 business days of receipt of the application.

a.i.b.6. Number and percentage of provider enrollment applications verified against the appropriate licensing entity and against additional specialty credentials.

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a.i.b.7. Number and percentage of providers having valid licensing criteria and the specialty credentials at the time of approval of the provider enrollment application. a.i.b.8. Number and percentage of inaccurate online enrollment update transactions and, of that number, percentage of detected errors which are corrected within one business day. a.i.b.9. Number and percentage of new and updated providers manuals available for distribution to enrolled providers within ten business days of written approval by DHS . a.i.b.10. Number and percentage of newsletters, bulletins, inserts and other special mailings available for distribution potential, new and enrolled providers within five business days of written approval by DHS. a.i.b.11. Number and percentage of provider manuals disseminated to newly enrolled providers within three business days of receipt of the request. a.i.b.12. Number and percentage of website updates of provider publications occurring within two business days of approval of the information by DHS. a.i.b.13. Number and percentage of monthly contract management reports on provider enrollment processes submitted within three (3) business days of the end of the reporting period. a.i.b.14. Number and percentage of monthly provider enrollment performance monitoring report cards submitted within ten (10) business days of the end of the reporting period. a.i.b.15. Number and percentage of operational procedure manuals updated and training on operational changes provided within two (2) weeks of the upgrade to newly enrolled and established providers. a.i.b.16. Number and percentage of responses/resolutions provided to the DHS IME Unit Managers Team within two (2) business days of receipt of requests made in any form (e.g., e-mail, phone) on provider enrollment issues. a.i.b.17. Number and percentage of responses/resolutions provided to the DHS IME Unit Managers Team within one (1) business day to DHS Project Management Team on emergency requests, as defined by the State, on provider enrollment issues. a.i.b.18. Number and percentage of deficiencies identified and provided to DHS within ten business days of receipt of discover of a problem found through the internal quality control reviews of provider enrollment processes. a.i.b.19. Number and percentage of corrective actions applied within ten business days of receipt of discover of a problem found through the internal quality control reviews of provider enrollment processes. a.i.b.20. Number and percentage of provider enrollment corrective action commitments not completed within the time frame specified. a.i.b.21. Number and amount of compensation withholdings annually applied for inaccurate and / or untimely provider enrollment issues. The contractual withholdings schedule and specific conditions for said withholdings are set forth in MEDS-04-015-C Contract_Provider Services. If the total amount withheld for failure to perform a requirement or meet a standard under this					

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Contract is greater than one hundred dollars ($100.00) for more than three (3) consecutive months during or after the term of the Contract the Contractor shall forfeit five (5%) of the withheld amount to DHS.

a.i.c. Execution of Medicaid provider agreements

a.i.c.1. Number and percentage of newly enrolled provider enrollment packets that do not contain a signed Medicaid provider agreement.

a.i.c.2. Number and percentage of provider enrollment packets without a signed Medicaid provider agreement appropriately remedied by Provider Services.

a.i.c.3. Number and percentage of provider re-enrollments having a timely enrollment renewal signature date on IMEservices.org.

a.i.c.4. Number and percentage of provider re-enrollments without a enrollment renewal signature appropriately remediably by Provider Services.

a.i.d. Quality assurance and quality improvement activities

a.i.d.1. Utilizing a statistically valid sample, a consumer survey shall demonstrate the number and percentage of Medicaid members that are:

1. Satisfied with the services which they receive,
2. Healthy and safe in their homes, and
3. Benefiting from service provision.

a.i.d.2. Number and percentage of technical assistance phone calls, on-site support or mailings to providers regarding remediation of HCBS requirement issues initiated within ten working days of referral.

a.i.d.3. Number and percentage of technical assistance on-site support visits to providers regarding resolution of certification / enrollment issues initiated within twenty working days of referral.

a.i.d.4. Number and percentage of corrective action plans required when the provider's policies and procedures are in non-compliance with Medicaid requirements and/or Iowa Administrative code. Corrective action plans will be categorized into one or more of the following remedial categories:

1. Non-compliance with existing rule requirements including policy and procedure implementation
2. Inappropriate billing issues
3. Complaint or abuse investigations regarding service implementation.
4. Enrollment / certification review issues
5. Issues addressing the health, safety, and welfare of waiver consumers

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6. Issues which may disrupt consumer service provision a.i.d.5. Number and percentage of consumer enrollment issues identified and appropriately remedied. a.i.d.6. Number and percentage of consumer utilization issues identified and appropriately remedied. a.i.d.7. Number and percentage of substantiated complaints that were individually remediated in a timely fashion. a.i.d.8. Number and percentage of quarterly contract management reports, which include data on waiting slot lists, service utilization by program / service, training activities, technical assistance activities, vacancies and updates on new hires no later than October 10, January 10, April 10 and July 10 of each year. a.i.d.9. Listing of statewide quarterly meetings including the following: 1. Coordination, operation and facilitation of ICN sites 2. Development of training material 3. Organization and distribution of training material 4. Departmental information letters and interagency transmittals 5. Requests for specific trainings by the Department, providers, case management entities, ISAC, and other stakeholders.					
SECTION GOALS: 1) To obtain CMS approval of a revised 3.5 waiver application, which incorporates recommendations from Thomson Reuters representative regarding performance measures, processes, data collection and analysis. **(Assurance a.i.; Action Steps A.1-2.)**					
A-1 Goal: To obtain CMS approval of a revised 3.5 waiver application, which incorporates recommendations from Thomson Reuters representative regarding performance measures, processes, data collection and analysis. **(Assurance a.i.; Action Steps A.1-2.)**					
a.i.a.1. – a.i.a.11. a.i.b.1. - a.i.b.21.	A.1.	Review and modify, as necessary, all performance measures, processes, data collection and analysis methods to accurately reflect current practices.	HCBS Services Unit	10/31/2008	

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a.i.c.1. - a.i.c.4. a.i.d.1. - a.i.d.9.					
a.i.a.1. – a.i.a.11. a.i.b.1. - a.i.b.21. a.i.c.1. - a.i.c.4. a.i.d.1. - a.i.d.9.	A.2.	Submit this work plan to CMS for approval.	Bureau of Long Term Care Services	10/31/2008	

B. LEVEL OF CARE: (Section B of the work plan outlines actions that must be completed for the state to collect, aggregate, report, and analyze data in accordance with performance measures specified in Appendix B (Evaluation / Reevaluation of Level of Care) of the 3.5 Waiver Application.)

PERFORMANCE MEASURES

Performance Measures (PM) related to each work plan action step is listed in the first column of the grid. For reference, all performance measures for this section are listed below.

a.i.a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

a.i.a.1. Number and percentage of initial level of care assessments not completed within two (2) business days of submission of a complete application.

a.i.a.2. Number and percentage of failed MMIS edit checks performed to determine whether submitted claims are valid for newly enrolled participants as measured by a valid LOC date.

a.i.b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

a.i.b.1. Number and percentage of members who have a level of care determination completed within 12 months of their initial evaluation or last annual reevaluation.

a.i.c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

a.i.c.1. Number and percentage of initial level of care determinations made for which the criterion was accurately and appropriately applied for the determination.

a.i.c.2. Number and percentage of reevaluation level of care determinations for which the criterion was accurately and appropriately applied for the determination.

SECTION GOALS:

1) To revise the established processes for collecting, reporting, aggregating and analyzing Medical Services Unit's performance and remediation data relative to the timeliness and accuracy of initial and annual level of care determinations. **(Sub-assurance a.i.a.1, a.i.b.1., a.i.c.1-2.; Action Steps B.1-3., B5-17.)**

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2) To collect performance data from the MMIS / ISIS systems relative to the timeliness of initial level of care determinations by monitoring the denial of claims where there is no LOC eligibility determination. **(Sub-assurance a.i.a.2; Action Steps B.4-8.)** 3) To revise the established processes for collecting, reporting, aggregating and analyzing performance and remediation data for continued stay reviews (CSR). **(Sub-assurance a.i.a.2, a.i.b.1.; Action Steps B.1., B.5-13.)** 4) To revise IME Medical Services Unit Waiver Programs Internal Quality Control Reviews to collect performance data relative the accuracy of initial and annual level of care determinations. **(Sub-assurance a.i.c.1-2.; Action Steps B.1., B.3., B.14-17.)**					
B-1 Goal: To revise the established processes for collecting, reporting, aggregating and analyzing Medical Services Unit's performance and remediation data relative to the timeliness and accuracy of initial and annual level of care determinations. **(Sub-assurance a.i.a.1, a.i.b.1., a.i.c.1-2.; Action Steps B.1-3., B5-17.)**					
a.i.a.1. a.i.b.1 a.i.c.1 a.i.c.2	B.1.	Finalize sampling methodology revisions to utilize representative sample at a 95% confidence level.	Medical Services Unit	7/1/2009	
a.i.a.1.	B.2.	Modify monthly and quarterly data reports from Medical Services to identify and remediate initial and annual level of care determinations not completed within (2) business days of receipt of a complete application.	Medical Services Unit	12/31/2008	
a.i.c.1 a.i.c.2	B.3.	Modify monthly reports from Medical Services to identify and remediate inaccurate initial and annual level of care determinations.	Medical Services Unit	11/1/2008	
B-2 Goal: To collect performance data from the MMIS / ISIS systems relative to the timeliness of initial level of care determinations by monitoring the denial of claims where there is no LOC eligibility determination. **(Sub-assurance a.i.a.2; Action Steps B.4-8.)**					
a.i.a.2	B.4.	Submit an IT request for generation of a monthly MMIS / ISIS report showing denials of claims because there is not a valid initial LOC eligibility determination.	Bureau of Long Term Care Services	12/31/2008	
a.i.a.2	B.5.	Revise current procedures into a written policy describing the process whereby waiver program managers' review monitored	Bureau of Long Term Care	5/1/2009	

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a.i.b.1.		claims for no valid initial level of care determination to show justification or remediation of these occurrences.	Services		
a.i.a.2 a.i.b.1.	B.6.	Begin generating a monthly MMIS / ISIS report showing denials for no valid initial LOC eligibility determination.	Bureau of Long Term Care Services	2/1/2009	
a.i.a.2 a.i.b.1.	B.7.	Establish a quarterly reporting mechanism listing justifications or remediation of instances where initial LOC eligibility determinations are not timely.	Bureau of Long Term Care Services	2/28/2009	
a.i.a.2 a.i.b.1.	B.8.	Begin utilization of the LOC reporting process for analysis by the QMC committee.	Bureau of Long Term Care Services	7/1/2009	
B-3 Goal: To revise the established processes for collecting, reporting, aggregating and analyzing performance and remediation data for continued stay reviews (CSR). **(Sub-assurance a.i.a.2, a.i.b.1.; Action Steps B.1., B.5-13.)**					
a.i.b.1.	B.9.	Revise current procedures into a written policy describing the process whereby waiver program managers monitor ISIS delinquent continued stay review reports to show justification or remediation of these occurrences.	Bureau of Long Term Care Services	5/1/2009	
a.i.b.1.	B.10.	Develop an electronic tracking tool to collect and analyze justification and / or remediation data on delinquent continued stay reviews.	Bureau of Long Term Care Services	5/1/2009	
a.i.b.1.	B.11.	Develop a format for monthly, quarterly and annual CSR Remediation Reports.	Bureau of Long Term Care Services	7/1/2009	
a.i.b.1.	B.12.	Begin monthly, quarterly and annual aggregation of data for CSR Remediation Reports.	Bureau of Long Term Care Services	7/1/2009	

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a.i.b.1.	B.13.	Produce the first monthly CSR Remediation Report showing remediation data for analysis by the QMC committee.	Bureau of Long Term Care Services	7/1/2009	
B-4 Goal: To revise IME Medical Services Unit Waiver Programs Internal Quality Control Reviews to collect performance data relative the accuracy of initial and annual level of care determinations. **(Sub-assurance a.i.c.1-2.; Action Steps B.1., B.3., B.14-17.)**					
a.i.c.1. a.i.c.2.	B.14.	Review and revise Internal Quality Control tool include new or revised components for documenting data on the accuracy of initial and annual level of care determinations.	Medical Services Unit	7/1/2009	
a.i.c.1. a.i.c.2.	B.15.	Revise Internal Quality Control procedures into a written process for reporting on the accuracy of initial and annual level of care determinations.	Medical Services Unit	11/1/2008	
a.i.c.1. a.i.c.2.	B.16.	Revise current Internal Quality Control procedures into written policies for resolution of inaccurate initial and annual level of care determinations.	Medical Services Unit	11/1/2008	
a.i.c.1. a.i.c.2.	B.17.	Begin utilization of the modified Medical Services Waiver QA Internal Quality Control documentation and reporting processes for analysis by the QMC committee.	Bureau of Long Term Care Services	11/1/2008	
C. QUALIFIED PROVIDERS: (Section C of the work plan outlines actions that must be completed for the state to collect, aggregate, report, and analyze data in accordance with performance measures specified in Appendix C (Participant Services) of the 3.5 Waiver Application.)					

PERFORMANCE MEASURES

Performance Measures (PM) related to each work plan action step are listed in the first column of the grid. For reference, all performance measures for this section are listed below.

a.i.a. Sub-assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. – across waivers.

a.i.a.1. Number and percentage of newly enrolled providers (licensed, certified, non-licensed) who met or did not meet provider criteria (by provider type).

a.i.a.2. Number and percentage of currently enrolled licensed / certified providers who met or did not meet provider criteria (by provider type).

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.b. Sub-assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements – across waivers. a.i.b.1. Number and percentage of currently enrolled non-licensed providers who met or did not meet provider criteria (by provider type). a.i.b.2. Number and percentage of newly enrolled non-licensed providers who met or did not meet provider criteria (by provider type). **a.i.c. Sub-assurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.** a.i.c.1. Number and percentage of providers (specific by service) that meeting training requirements as outlined in the provider manual.					
SECTION GOALS: 1) To review and revise the established processes for collecting, reporting, aggregating and analyzing Provider Services Unit's performance and remediation data to ensure that initially and on a continuous basis licensed / certified providers meet all applicable waiver standards. **(Sub-assurance a.i.a.1-2; Action Steps C.1-3.)** 2) To review and revise the established processes for collecting, reporting, aggregating and analyzing Provider Services Unit's performance and remediation data to ensure that initially and on a continuous basis unlicensed / non-certified providers meet all applicable waiver standards. **(Sub-assurance a.i.b.1-2); Action Steps C.4-5.)** 3) To review and revise the HCBS Services Unit 's established provider oversight processes to verify and ensure that waiver providers are compliant with all applicable training requirements. **(Sub-assurance a.i.c.1.; Action Steps C.6-8.)**					
C-1 Goal: To review and revise the established processes for collecting, reporting, aggregating and analyzing Provider Services Unit's performance and remediation data to ensure that initially and on a continuous basis licensed / certified providers meet all applicable waiver standards. **(Sub-assurance a.i.a.1-2; Action Steps C.1-3.)**					
a.i.a.1.	C.1.	Modify monthly and quarterly data reports to report applications approved and denied by provider type.	Provider Services Unit	7/1/2009	
a.i.a.2.	C.2.	Develop a strategy and schedule to assure reenrollment of all waiver providers on a four-year cycle.	Provider Services Unit	7/1/2009	
a.i.a.2. a.i.b.1.	C.3.	Coordinate Provider Services reenrollment process with HCBS Services provider oversight process so all performance and remediation data is available.	Provider Services Unit / HCBS Services Unit	7/1/2009	
C-2 Goal: To review and revise the established processes for collecting, reporting, aggregating and analyzing Provider Services Unit's performance and remediation data to ensure that initially and on a continuous basis unlicensed / non-certified providers meet all applicable waiver standards. **(Sub-assurance a.i.b.1-2); Action Steps C.4-5.)**					

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.b.2	C.4.	Modify monthly and quarterly data reports from Provider Services to report applications approved and denied by provider type.	Provider Services Unit	7/1/2009	
a.i.b.1.	C.5.	Develop a strategy and schedule to assure reenrollment of all waiver providers on a four-year cycle.	Provider Services Unit	7/1/2009	
C-3 Goal: To review and revise the HCBS Services Unit 's established provider oversight processes to verify and ensure that waiver providers are compliant with all applicable training requirements. **(Sub-assurance a.i.c.1.; Action Steps C.6-8.)**					
a.i.c.1.	C.6.	Revise the HCBS Services unit provider oversight process to require provider training information on an annual basis.	HCBS Services Unit	7/1/2009	
a.i.c.1.	C.7.	Develop an electronic mechanism to input and analyze training data, individual provider remediation activities and statewide system remediation activities.	HCBS Services Unit	7/1/2009	
a.i.c.1.	C.8.	Develop a format for quarterly and annual Provider Training reports.	HCBS Services Unit	7/1/2009	
D. SERVICE PLAN: (Section D of the work plan outlines actions that must be completed for the state to collect, aggregate, report, and analyze data in accordance with performance measures specified in Appendix D (Participant-Centered Planning and Service Delivery) of the 3.5 Waiver Application.)					

PERFORMANCE MEASURES

Performance Measures (PM) related to each work plan action step are listed in the first column of the grid. For reference, all performance measures for this section are listed below.

a.i.a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

a.i.a.1. Number and percentage of service plans where risks are addressed.

a.i.a.2. Number and percentage of service plans consistent with all needs identified in the assessment including needs addressed by sources other than HCBS waiver services.

a.i.b. Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.b.1. Number and percentage of TCM/CM/SW progress notes which indicate that contacts with the member occurred on a timely basis. **a.i.c. Sub-assurance: Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.** a.i.c.1. Number and percent of service plans which are revised annually. a.i.c.2. Number and percentage of records indicating that plans were revised when warranted by a change in level of care. **a.i.d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.** a.i.d.1. Number and percentage of member surveys reporting the receipt of all services identified in the plan. **a.i.e. Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.** a.i.e.1. Number and percentage of members whose records contain an appropriately completed and signed statement of choice that specifies that choice was offered between waiver services and institutional care. a.i.e.2. Number and percentage of members who indicated that they received a choice of waiver providers.					
SECTION GOALS: 1) To revise Medical Services Unit Waiver Programs QA Desk Reviews to collect performance data relative to the accuracy and effectiveness of the service plan. **(Sub-assurance a.i.a.1-2, a.i.c.1., a.i.e.1; Action Steps D. 1-7.)** 2) To revise the established processes for collecting, reporting, aggregating and analyzing remediation data from Medical Services Unit Waiver Programs QA Desk Reviews. **(Sub-assurance a.i.a.1-2, a.i.c.1., a.i.e.1.; Action Steps D.1-7.)** 3) To revise the established processes for collecting, reporting, aggregating and analyzing member survey (I-PES) data and remediation data relative to the receipt of services. **(Sub-assurance a.i.d.1., a.i.e.2.; Action Steps D.1., D.8-14.)** 4) To collect, report, aggregate and analyze performance and remediation data from ISIS relative to service plans, plan updates and choice of providers. **(Sub-assurance a.i.b.1., a.i.c.2. Action Steps D.1-17.)**					
D-1 Goal: To revise Medical Services Unit Waiver Programs QA Desk Reviews to collect performance data relative to the accuracy and effectiveness of the service plan. **(Sub-assurance a.i.a.1-2, a.i.c.1., a.i.e.1; Action Steps D. 1-7.)**					
a.i.a.1-2, a.i.b.1., a.i.c.1-2.,	D.1.	Finalize sampling methodology revisions to utilize representative sample at a 95% confidence level.	Medical Services Unit	7/1/2009	

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.d.1., a.i.e.1-2.					
a.i.a.1-2, a.i.b.1., a.i.c.1-2., a.i.e.1-2.	D.2.	Review and revise desk review tools to include new or revised components for documenting; (a) the identification of health and safety risks, (b) identification of member needs, (c) plan development, and (d) member choice.	Medical Services Unit	6/1/2009	
a.i.a.1-2, a.i.b.1., a.i.c.1-2., a.i.e.1-2.	D.3.	Revise and coordinate desk review procedures into a written for reporting on the status of the plan in regard to; (a) the identification of health and safety risks, (b) identification of member needs, (c) plan development, and (d) member choice.	Medical Services Unit / HCBS Services Unit	7/1/2009	
a.i.a.1-2, a.i.b.1., a.i.c.1-2., a.i.e.1-2.	D.4.	Begin utilization of the modified Medical Services Waiver QA Desk Reviews documentation and reporting processes for analysis by the QMC committee.	Bureau of Long Term Care Services	7/1/2009	
D-2 Goal: To revise the established processes for collecting, reporting, aggregating and analyzing remediation data from Medical Services Unit Waiver Programs QA Desk Reviews. **(Sub-assurance a.i.a.1-2, a.i.c.1., a.i.e.1.; Action Steps D.1-7.)**.					
a.i.a.1-2, a.i.b.1., a.i.c.1-2., a.i.e.1.	D.5.	Revise desk review procedures into a written for reporting on the status of the plan in regard to; (a) the identification of health and safety risks,	Medical Services Unit	6/1/2009	

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
		(b) identification of member needs, (c) plan development, and (d) member choice.			
a.i.a.1-2, a.i.b.1., a.i.c.1-2., a.i.e.1.	D.6.	Revise current desk review procedures into written policies for remediation of the lack of service plan components including those addressing: (a) the identification of health and safety risks, (b) identification of member needs, (c) plan development, and (d) member choice.	Bureau of Long Term Care Services	6/1/2009	
a.i.a.1-2, a.i.b.1., a.i.c.1-2., a.i.e.1.	D.7.	Begin utilization of the modified Medical Services Waiver QA Desk Reviews documentation and reporting processes for analysis by the QMC committee.	Bureau of Long Term Care Services	7/1/2009	
D-3 Goal: To revise the established processes for collecting, reporting, aggregating and analyzing member survey (I-PES) data and remediation data relative to the receipt of services. **(Sub-assurance a.i.d.1., a.i.e.2.; Action Steps D.1., D.8-14.)**					
a.i.d.1., a.i.e.2.	D.8.	Finalize sampling methodology revisions to utilize representative sample at a 95% confidence level.	HCBS Services Unit	1/31/2009	
a.i.d.1., a.i.e.2.	D.9.	Finalize modification of I-PES processes and coordinate the collecting, reporting and aggregating of data regarding the planning and receipt of identified services.	HCBS Services Unit / Medical Services Unit	1/31/2009	
a.i.d.1., a.i.e.2.	D.10.	Finalize modification of I-PES follow up reports to identify and remediate inconsistencies in the planning and receipt of identified services.	HCBS Services Unit	1/31/2009	

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.d.1., a.i.e.2.	D.11.	Develop a format for monthly, quarterly and annual I-PES Remediation Reports.	HCBS Services Unit	2/28/2009	
a.i.d.1., a.i.e.2.	D.12.	Begin monthly, quarterly and annual aggregation of data for I-PES Remediation Reports.	HCBS Services Unit	3/1/2009	
a.i.d.1., a.i.e.2.	D.13.	Produce the first monthly I-PES Remediation Report showing remediation data for analysis by the QMC committee.	Bureau of Long Term Care Services	4/30/2009	
D-4 Goal: To collect, report, aggregate and analyze performance and remediation data from ISIS relative to service plans, plan updates and choice of providers. **(Sub-assurance a.i.b.1., a.i.c.2.; Action Steps D.1-17.)**					
a.i.b.1., a.i.c.1-2., a.i.e.2.	D.14.	Submit IT requests to: a) modify an IM milestone regarding choice of waiver over institutional care, b) add a service plan milestone regarding choice of waiver services and providers, c) generate a monthly ISIS report showing service plans which have not been reviewed in the past 12 month time period, and d) generate a monthly ISIS report to show service plans which were not revised following a level of care change.	Bureau of Long Term Care Services	12/31/2008	
a.i.c.1-2.	D.15.	Begin generating a monthly ISIS report showing service plans which have not been reviewed in the past 12 month time period and service plans which have not been updated following a level of care change.	Bureau of Long Term Care Services	7/1/2009	
a.i.c.1-2.	D.16.	Establish a quarterly reporting mechanism listing justifications or remediation of instances where service plans were not reviewed in the past 12 month time period or updated following a level of	Bureau of Long Term Care Services	7/1/2009	

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
		care change.			
a.i.b.1., a.i.c.1-2.	D.17.	Begin utilization of the POC reporting process for analysis by the QMC committee.	Bureau of Long Term Care Services	7/1/2009	

G. HEALTH & WELFARE: The state, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect and exploitation. (Section G of the work plan outlines actions that must be completed for the state to collect, aggregate, report, and analyze data in accordance with performance measures specified in Appendix G (Participant Safeguards) of the 3.5 Waiver Application.)

PERFORMANCE MEASURES

Performance Measures (PM) related to each work plan action step are listed in the first column of the grid. For reference, all performance measures for this section are listed below.

a.i. For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

a.i.1. Number and type of critical incidents, by type.
a.i.2. Average number of critical incidents per waiver recipient.
a.i.3. Number of waiver member deaths from unexplained or suspicious causes.
a.i.4. Number and percentage of unreported critical incidents that should have been reported.
a.i.5. Number and percentage of I-PES survey respondents who indicated knowledge of how to report instances of abuse, neglect or exploitation.
a.i.6. Number and percentage of I-PES survey respondents who reported that people take their things without asking.
a.i.7. Number and percentage of I-PES survey respondents who reported that staff yell or scream at them.
a.i.8. Number and percentage of I-PES survey respondents who reported they do now feel safe where they live.
a.i.9. Number and percentage of I-PES survey respondents who reported they are not retreated with respect and dignity.

SECTION GOALS:

1) Define a more comprehensive incident, complaint, and restraint management process by reviewing current state systems and designing an efficient infrastructure for incident and remediation information. **(Assurance a.i.1-4; Action Steps G.1-12.)**
2) Determine methods and systems for uniform incident, complaint and restraint management across disabilities and waiver programs.**(Assurance a.i.1-4.; Action Steps G.1-12.)**
3) To revise IME Medical Services Unit Waiver Programs QA Desk Reviews to collect data on unreported critical incidents that should have been reported. **(Assurance a.i.4.; Actions Steps G.1-12.)**
4) To improve the mortality review process by incorporating a medical review. **(Assurance a.i.3.; Action Steps G.1-4., G.8-12.)**
5) To revise the established processes for collecting, reporting, aggregating and analyzing member survey (I-PES) data and remediation data regarding health and safety concerns.

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
(Assurance a.i.5-9.; Action Steps G.13-18.)					
G-1 Goal: Define a more comprehensive incident, complaint, and restraint management process by reviewing current state systems and designing an efficient infrastructure for incident and remediation information. **(Assurance a.i.1-4; Action Steps G.1-12.)**					
a.i.1-3.	G.1.	Review incident, complaint and restraint management systems utilized in other states.	HCBS Services Unit	12/31/2008	
a.i.1-3.	G.2.	Submit an IT request to review information obtained for compatibility with the data warehouse.	Bureau of Long Term Care Services	2/1/2009	
G-2 Goal: Determine methods and systems for uniform incident, complaint and restraint management across disabilities and waiver programs.**(Assurance a.i.1-4.; Action Steps G.1-12.)**					
a.i.1-3.	G.3.	Submit an administrative rule change to require implementation of comprehensive incident, complaint, and restraint management standards across waiver programs.	Bureau of Long Term Care Services	12/31/2008	
a.i.1-4.	G.4.	Implement a comprehensive and efficient incident, complaint, and restraint management system.	Bureau of Long Term Care Services	7/1/2009	
G-3 Goal: To revise IME Medical Services Unit Waiver Programs QA Desk Reviews to collect data on unreported critical incidents that should have been reported. **(Assurance a.i.4.; Actions Steps G.1-12.)**					
a.i.4.	G.5.	Review and revise desk review tools to include new or revised components for documenting unreported critical incidents that should have been reported.	Medical Services Unit	6/1/2009	
a.i.4.	G.6.	Begin utilization of the modified Medical Services Waiver QA Desk Reviews documentation and reporting processes.	Medical Services Unit	7/1/2009	
a.i.4.	G.7.	Modify monthly and quarterly data reports from Medical Services to identify and remediate unreported critical incidents that should have been reported.	Bureau of Long Term Care Services	7/1/2009	
G-4 Goal: To improve the mortality review process by incorporating a medical review. **(Assurance a.i.3.; Action Steps G.1-4., G.8-12.)**					

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.3.	G.8.	Review mortality review systems utilized in other states.	HCBS Services Unit	12/31/2008	
a.i.3.	G.9.	Develop mortality review screening requirements for an additional review by a medical professional.	HCBS Services Unit	2/1/2009	
a.i.3.	G.10.	Develop a format for monthly, quarterly and annual Mortality Review Reports.	HCBS Services Unit	4/1/2009	
a.i.3.	G.11.	Begin monthly, quarterly and annual aggregation of data for Mortality Review Reports.	HCBS Services Unit	7/1/2009	
a.i.3.	G.12.	Produce the first monthly Mortality Review Report.	Bureau of Long Term Care Services	7/1/2009	
G-5 Goal: To revise the established processes for collecting, reporting, aggregating and analyzing member survey (I-PES) data and remediation data regarding health and safety concerns. **(Assurance a.i.5-9.; Action Steps G.13-18.)**					
a.i.5-9.	G.13.	Finalize sampling methodology revisions to utilize representative sample at a 95% confidence level.	HCBS Services Unit	7/1/2009	
a.i.5	G.14.	Submit an IT request for incorporation of consumer survey data and reporting formats into the data warehouse.	Bureau of Long Term Care Services	3/31/2009	
a.i.5	G.15.	Finalize the revision of established processes and modify I-PES follow up reports to identify and remediate issues of health, safety, abuse, and neglect.	HCBS Services Unit	1/31/2009	
a.i.5	G.16.	Develop a format for monthly, quarterly and annual I-PES Incident Reports.	HCBS Services Unit	2/28/2009	
a.i.5	G.17.	Begin monthly, quarterly and annual aggregation of data for I-PES Remediation Reports.	HCBS Services Unit	3/1/2009	

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PM No.	**Action Step No.**	**Action Steps**	**Responsible Agency/Staff**	**Target Date for Completion**	**Status**
a.i.5	G.18.	Produce the first monthly I-PES Incident Report showing remediation data for analysis by the QMC committee.	Bureau of Long Term Care Services	4/30/2009	

I. FINANCIAL ACCOUNTABILITY: The state demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program. (Section I of the work plan outlines actions that must be completed for the state to collect, aggregate, report, and analyze data in accordance with performance measures specified in Appendix I (Financial Accountability) of the 3.5 Waiver Application.)

PERFORMANCE MEASURES

Performance Measures (PM) related to each work plan action step are listed in the first column of the grid. For reference, all performance measures for this section are listed below.

a.i. For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

a.i.1. Number and percent of claims coded as specified in the waiver application.
a.i.2 Number and percent of claims paid at the correct rate.
a.i.3 Number and percent of claims paid for services not documented.

SECTION GOALS:

1) To modify ISIS and SURS reporting procedures. **(Assurance a.i.; Actions Steps I.1-2.)**

I-1 Goal: To modify ISIS and SURS reporting procedures. **(Assurance a.i.; Actions Steps I.1-2.)**

a.i.1. a.i.3.	I.1.	Modify monthly and quarterly data reports from SURS to identify and remediate paid claims without substantiating documentation.	SURS Unit	2/1/2009	
a.i.2.	I.2.	Begin generating a monthly ISIS report showing claims paid for more than the approved rate.	Bureau of Long Term Care Services	7/1/2009	